Date Received _____

State Health Insurance Assistance Program (SHIP)

www.medicareabcd.org 301-255-4250 SHIP@accessJCA.org

Medicare Prescription Drug Plan Worksheet for 2020

SHIP can help you analyze your options for your 2020 Prescription Drug Plan. (Original Medicare only. For Medicare Advantage options, call 1-800-Medicare.) For coverage beginning January 1, 2020, **mail your form no later than November 10, 2019!**

➢ **Mail your completed form to:** State Health Insurance Assistance Program (SHIP)
12320 Parklawn Drive, Rockville, MD 20852

Name: _____

Address: _____

City: _____ **ZIP Code:** _____

Home Telephone: _____ O**ther Telephone:** _____

Name 2 retail pharmacies you are willing to use for prescriptions (e.g. CVS, Giant, Walmart)

1. _____ 2. _____

Insurance Information

Please tell us the Medicare Part D Prescription Drug Plan you are currently enrolled (if any) so we can compare your present plan with 2020 options.

Company: _____ **Monthly Premium**: $_____

Exact Name of Plan: _____

If you are new to Medicare, what month/year will your Medicare Part D coverage start? _____

I will be enrolled in **an employer health plan or FEHBP in 2020.**	☐ Yes ☐ No
I have **Extra Help (LIS)** **If YES**, please specify: ☐ 100% subsidy (you pay $3.35/$8.35) ☐ Partial Subsidy	☐ Yes ☐ No
I have **Medicaid** (Medical Assistance)	☐ Yes ☐ No
I am enrolled in the **Maryland Senior Prescription Drug Assistance Program. (SPDAP)** (I get help with my premium –up to $40/ month in 2019)	☐ Yes ☐ No

If your income is below $37,470 (single) or $50,730 (couple), you may be eligible for the LIS (Extra Help) or SPDAP program depending on your income and assets.

Jewish Council for the Aging® *Helping All Seniors Thrive®*

ship state health insurance assistance program maryland

Maryland SMP Empowering Seniors To Prevent Healthcare Fraud

Instructions

Please list all of your on-going prescription drugs. **List the full drug name as it appears on the bottle** (e.g. Atenolol), including if it is **Extended Release** (ER).

- Indicate if your drug is a brand-name medication or generic. (Ask your pharmacist if unsure.) We will assume you take the brand name unless you specify generic.
- List the drug strength, frequency, and form (e.g., capsule, drops).
- Do not include over-the-counter medications.

Please print clearly.

Full Name of Drug (e.g. Atenolol)	**Specify Brand or Generic**	**Strength of Prescription** (e.g. 50 mg)	**Frequency** (e.g., once per day- indicate 1x,)	**Capsule, tablet, ointment, creams, drops**
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
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Attach another page if necessary

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