For Office Use Only

ID #: Date Rec'd: ☐ Gen ☐ LIS ☐ SPDAP ☐ MCAID

Montgomery County State Health Insurance Assistance Program (SHIP)
www.MedicareABCD.org 301-255-4250 SHIP@AccessJCA.org

2021 Medicare Drug Plan Worksheet

Montgomery County SHIP can help you analyze your options for your 2021 Part D Prescription Drug Plan. For coverage to begin January 1, 2021, send your form **before November 16, 2020!**

- **For faster results, use the secure online form at:** www.MedicareABCD.org/Forms-Resources/
- **OR send your completed form to:** **Email** SHIP@AccessJCA.org
  Mail **Montgomery County SHIP**
  12320 Parklawn Drive, Rockville, MD 20852

Name: _____

Address: _____

City: _____ **ZIP Code:** _____

Telephone: Home _(_____)_____-_____ **Other** __(_____)_____-_____

Email: _____ **Email my results for faster delivery** ☐ Yes ☐ No

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

1st Choice _____ **2nd Choice** _____

Insurance Information

Please tell us your current Medicare Part D Prescription Drug Plan (if any).

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 2021.**	☐ Yes ☐ No
I have **Extra Help (LIS)** **If YES**, please specify: ☐ 100% subsidy (you pay $3.60/$8.95) ☐ 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 2020.)	☐ Yes ☐ No

You may be eligible for Extra Help from Medicare depending on your income and assets. You may be eligible for Maryland's SPDAP if your income is below $38,280 (single) or $51,720 (couple), regardless of 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 your prescription drugs. Do not include over-the-counter medications.

- List the **full drug name as it appears on the bottle**, 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.
- For **Quantity**, if other than tablets or capsules, be specific about how many tubes/bottles/packs/ inhalers/etc. you need per month or per year.
- **Attach another page if necessary.**

Please print clearly.

Full Name of Drug	Specify Brand or Generic	Strength of Prescription	Quantity (once per day, indicate 1 x)	Capsule, tablet, ointment, creams, drops
EXAMPLE Coumadin	☑ Brand Only ☐ Generic	5 mg	2 x	tablet
EXAMPLE Latanoprost	☐ Brand Only ☑ Generic	.005%	One 2.5 ml bottle every 2 months	drops
	☐ **Brand Only** ☐ **Generic**			
	☐ **Brand Only** ☐ **Generic**			
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