For Office Use Only

ID #: Date Rec'd: ☐ GEN ☐ SPDAP ☐ EHELP

Montgomery County State Health Insurance Assistance Program (SHIP)

www.MedicareABCD.org 301-255-4250 SHIP@AccessJCA.org

2022 Medicare Part D Plan Comparison Request

Montgomery County SHIP can help you select the Medicare prescription drug plan (PDP) that best meets your needs for 2022. To compare your options, we need information about the pharmacies you use and the drugs you take routinely. The deadline for switching plans is **December 7**. (For Medicare Advantage options, call 1-800-MEDICARE.)

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

Name: _____

Address: _____

City: _____ **ZIP Code:** _____

Phone #: (_____)_____ **Alternate #:** (_____)_____

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). **Exact Name of Plan:** _____ **Monthly Premium**: $_____ (e.g., SilverScript Choice or Elixir RX Plus)	
If you are new to Medicare PART D, when will your Part D coverage start? MM / YYYY	
I will be enrolled in an **employer/union or retiree health plan in 2022.**	☐ Yes ☐ No
I have **Extra Help (LIS) or Medicaid.** **If YES**, please specify: ☐ 100% subsidy (you pay $3.70/$9.20) ☐ Partial Subsidy	☐ Yes ☐ No
I am enrolled in the **Maryland Senior Prescription Drug Assistance Program (SPDAP).** (I get help with my premium – up to $50/month in 2021.)	☐ 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 $38,640 (single) or $52,260 (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.***

Please print clearly.

Full Name of Drug)	**Specify Brand or Generic**	**Prescription Strength**	**Quantity** (1/day, 3/mo., etc.)	**Form Capsule, tablet, tube, drops**
EXAMPLE Coumadin	☑ Brand Only ☐ Generic	5 mg	2/day	tablet
EXAMPLE Latanoprost	☐ Brand Only ☑ Generic	.005%	One 2.5 ml bottle every 2 months	drops
	☐ **Brand Only** ☐ **Generic**			
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Attach another page if necessary.