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

2024 Medicare Drug Plan Comparison Request

Montgomery County SHIP can help you select the Medicare drug plan that best meets your needs for 2024. 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.)

Please send us your completed form before November 22, 2023:

- **For faster results, use secure online form** www.MedicareABCD.org/plan-comparison
- **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 results for faster delivery** ☐ Yes ☐ No

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

1_____ **2**_____

Insurance Information	
Please identify your current Medicare drug plan (if any). ☐ None **Exact Name of Plan:** _____ **Monthly Premium**: $_____ (e.g., SilverScript Choice or Wellcare Value Script)	
I will have **employer/union or retiree health coverage in 2024.**	☐ Yes ☐ No
I have **Extra Help (LIS) or Medicaid**.	☐ Yes ☐ No
I am enrolled in the **Maryland Senior Prescription Drug Assistance Program (SPDAP).** (I get help with my premium – up to $60 per month in 2023.)	☐ 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 $43,740 (single), or $59,160 (couple), regardless of assets.

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

SHIP State Health Insurance Assistance Program — Navigating Medicare

SMP Senior Medicare Patrol — Preventing Medicare Fraud

Made possible with a grant from the US Administration for Community Living Through the State of Maryland.

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 **Frequency** if other than tablets or capsules, ***be specific about how many tubes/bottles/packs/ inhalers/etc. you buy per month or per year.***

Please print clearly.

Full Name of Drug	Specify Brand or Generic	Prescription Strength	Frequency	Form Capsule, tablet, tube, drops
CAPSULES / TABLETS			# pills per day or per month	
EXAMPLE Coumadin	☑ Brand Only ☐ Generic	5 mg	2 pills/day	tablet
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
BOTTLES / TUBES / PACKS / INHALERS ETC.			# bottles (etc) bought per month or per year	Type - drops, cream, ointment, gel, inhaler, other
EXAMPLE Latanoprost	☐ Brand Only ☑ Generic	.005%	One 2.5 ml bottle every 2 months	drops
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			
	☐ Brand Only ☐ Generic			

* * Attach another page if necessary * *

8/19/23