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

2025 Medicare Drug Plan Comparison Request

Montgomery County SHIP can help you select the Medicare drug plan that best meets your needs for 2025. To compare your options, we need information about the pharmacies you use and the drugs you take routinely. The deadline for switching drug plans is **December 7**. (For assistance with switching from traditional Medicare to Medicare Advantage, please call our office.)

Please send us your completed form before November 25, 2024:

- **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 2025.**	☐ Yes ☐ No
I get **Extra Help (LIS) or Medicaid**.	☐ Yes ☐ No
I am enrolled in the **Maryland Senior Prescription Drug Assistance Program (SPDAP)** (to help pay my plan premium – up to $75 per month in 2024).	☐ Yes ☐ No

You may be eligible for Extra Help from Social Security 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.

Instructions

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.

Please list all your prescription drugs. Do not include over-the-counter medications.

- List the **full drug name as it appears on the container**, including if it is Extended Release (ER).
- Check the box if you are unable to use the **generic** and must use the **brand-name** version.
- For "other than pills," be specific about how many tubes/bottles/packs/inhalers/etc. you **purchase** per month or per year.

Full Name of Drug		Form	Dosage	Quantity / Frequency
PILLS: Tablets or capsules		Tablet or capsule	mg, mcg, etc.	**# pills taken** per day or per month
EXAMPLE Synthroid	☑ cannot use generic	tablet	75 mcg	1 pill/day
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OTHER THAN PILLS: Drops, solution, **c**ream, gel, ointment, inhaler, etc.		Type	# of gm, ml, etc.	**# bottles, tubes, or packs bought** per month or per year
EXAMPLE Clindamycin 1%	☐ cannot use generic	gel	30 gm	One tube every 3 months
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	☐ cannot use generic			

* * Attach another page if necessary * *