

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

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

Medicare Drug Plan Comparison Request for 2026

If you have Original Medicare, Montgomery County SHIP can help you select the Medicare drug plan that best meets your needs for 2026. To compare your options, we need information about your prescription drugs and pharmacies. **The deadline for switching drug plans is December 7.** (For assistance with Medicare Advantage plans, please call our office.)

Please send us your completed form before **November 26, 2025:**

- **For faster results, use our online form at** 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 (e.g. CVS, Giant, Walmart, Costco)

1 _____ 2 _____

Insurance Information	
Please identify your <u>current</u> Medicare drug plan (if any).	<input type="checkbox"/> 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 2026.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I get Extra Help (LIS) or Medicaid.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 2025).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.



Please list all prescription drugs you take regularly. Do not include over-the-counter items.

- List the **full drug name** as it appears on the container, including if it is **Extended Release (ER)**.
- Check the box if you are cannot take 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 <input checked="" type="checkbox"/> cannot take generic	tablet	75 mcg	1 pill/day
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
OTHER THAN PILLS: Drops, solution, cream, gel, ointment, inhaler, etc.	Type	# of gm, ml, etc.	# bottles, tubes, or packs bought per month or per year
EXAMPLE Clindamycin 1% <input type="checkbox"/> cannot take generic	gel	30 gm	One tube every 3 months
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			
<input type="checkbox"/> cannot take generic			