

ID #:

Date Rec'd:

☐ GEN ☐ SPDAP ☐ EHELP

Montgomery County State Health Insurance Assistance Program (SHIP)

www.MedicareABCD.org

301-255-4250

SHIP@JSSA.org

Medicare Drug Plan Comparison Request for 2027

If you have Original Medicare, Montgomery County SHIP can help you select the Medicare drug plan that best meets your needs for 2027. To compare your options, we need information about your prescription drugs and pharmacies. **The deadline for switching drug plans is December 7th.** (For assistance with Medicare Advantage plans, please call our office.)

Please send us your completed form before **November 25, 2026:**

For faster results, use our online form at:

www.MedicareABCD.org/plan-comparison

Note: If you want results emailed to you, SHIP will do so by secure email to protect your privacy. You will be instructed on setting up an account and password.

OR send your completed form by mail or email

Montgomery County SHIP

12320 Parklawn Drive, Rockville, MD 20852

SHIP@JSSA.org (Note new email address!)

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	
I am new to Medicare Part D.	☐ Yes ☐ No
If YES, when will your coverage start? (MM/YY) _____ <i>Caution: Some retiree plans may cancel a retiree's medical and drug coverage if the retiree joins a Medicare plan. If you will have retiree coverage from an employer, ask their HR department about this before enrolling in Part D.</i>	
If NO, please identify your current (2026) Medicare drug plan.	
Exact Name of Plan: _____ (e.g., SilverScript Choice or Wellcare Value Script)	Monthly Premium: \$ _____
I get Extra Help (LIS) or Medicaid . <i>Eligibility depends on your income and assets. Contact SHIP for more information.</i>	☐ Yes ☐ No
I am enrolled in the Maryland Senior Prescription Drug Assistance Program <i>Eligibility depends on income; there is no asset limit. Contact SHIP for more information.</i>	☐ Yes ☐ No



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 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 Medication		Form	Dosage	Quantity / Frequency
PILLS: Tablets or capsules		Tablet or capsule	mg, mcg, etc.	# pills taken per day or per month
EXAMPLE Synthroid	☒ cannot take generic	tablet	75 mcg	1 pill/day
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	☐ cannot take generic			
	☐ cannot take generic			
	☐ cannot take generic			
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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%	☐ cannot take generic	gel	30 gm	One tube every 3 months
	☐ cannot take generic			
	☐ cannot take generic			
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	☐ cannot take generic			

* * Attach additional page(s) if necessary * *