## MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

Open enrollment is the time of year to check your Part D plan to make sure it is still the best one for you. If you fill out this form and return it to us, we will do an analysis to determine if there is a better plan for you in 2022. It is all about saving you money. You may find it helpful to gather all of your prescription medication bottles and your red, white and blue Medicare card to help you complete this form.

Please return this form to:

Central Virginia Alliance for Community Living VICAP oremail:frontdesk@cvcl.org501 12th Street, Lynchburg, Va 24504fax: 434-385-9209

1	What is your Zip Code?	<u> </u>	
	What is your Medicare Number?	MEDICARE HEALTH INSURANCE	
۷.		Name/Nombre	
		JOHN L SMITH	
3.	What is your Name (as it appears on your card)?	Medicare Number/Número de Medicare	
		IEG4-TE5-MK72         Coverage starts/Cobertura empieza           Entitled to(Con direcho a         Coverage starts/Cobertura empieza           Coverage starts/Cobertura empieza         Coverage starts/Cobertura empieza	
	Last name Jr. Sr. III	HOSPITAL (PART A) 03-01-2016 MEDICAL (PART B) 03-01-2016	
	First Name		
	What is your effective date (when you first enrolled) for	MEDICARE HEALTH INSURANCE	
IVIE	edicare Part A?	Str.	
		JOHN L SMITH	
Wł	nat is your effective date (when you first enrolled) for		
Me	edicare Part B?	Medicare Number/Namero de Medicare 1EG4-TE5-MK72	
		Entitled talCan derecho a Coverage starts/Cobertura empieza HOSPITAL (PART A) 03-01-2016 MEDICAL (PART B) 03-01-2016	
5. ۱	What is your Date of Birth?		
ſ	Month Day Year		
	Nhat is your street address?		
71	n what County do you live? Bedford Campbell App	oomattox	
8. \	What is your email address?		
9. \	What is your telephone number?		
	Please continue on the othe	er side	

For office use:

Received				
Appt date				
Counselor				
Complete				
ACL				
Data base				
Original				
New				

10. What Prescription Drug Coverage do you now have?

- Medicare Prescription Drug plan\_\_\_\_\_\_Monthly premium\_\_\_\_\_\_
   complete name of current plan
- Medicare Advantage Plan\_\_\_\_\_
- □ Virginia Medicaid
- I have Extra Help with my medications (I pay no more than \$3.95 for generics and \$9.85 for Brand names)

complete name of current plan

## 11. Which prescription medications do you currently take?

Please enter your prescription medications. *Please give exact name of drug, including ER, XR etc. If you take generics, please give only the generic name.* 

<u>I you take generies, pieuse give only the generie namer</u>				
Name of Prescription Drug	Dosage: example:500mg for pills, tablets; or 0.5 % for solutions or creams Size 2.0oz bottle or .5 oz tube	How much you buy for 1 month (30 days) Example: 30 pills, 1 tube, 1 box of 60 aerosols, 1 box of 5 pens) Do NOT put "as needed"		
For example: Atorvastatin	20 mg	30 per month		

Please use additional sheets if needed

*List 2 pharmacies you prefer using:* 

Pharmacy name\_\_\_\_\_\_ Pharmacy name\_\_\_\_\_

We are happy to help you regardless of your income, but if you can answer **YES** to this question, you may be eligible for extra help with your medication costs (and pay no more than \$3.95 for generics and \$9.85 for brand names) *Is your monthly income and combined assets (other than your home and car) less than*:

- □ YES \$1719 income/\$15,510 assets if you live alone or
- □ YES \$2309 income/\$30,950 assets if you are married and living together?