Medicare Open Enrollment Period (Oct. 15 – Dec. 7)

Medicare Part D Prescription Drug Plan Finder Tool

855-408-1212 • www.ncshiip.com

The Seniors' Health Insurance Information Program (SHIIP) can help you find a Medicare Prescription Drug Plan to meet your needs and assist you with enrolling in a plan. The following questionnaire provides the information that SHIIP staff and volunteers need to prepare a report for your consideration.

SHIIP
NC DEPARTMENT OF INSURANCE
MIKE CAUSEY, COMMISSIONER

Once completed, **please take this form to a counseling clinic in your county** or mail to:
North Carolina SHIIP, 1201 Mail Service Center, Raleigh NC 27699-1201

Name: _____ **Date of Birth:** _____
(Please provide your name as it appears on your Medicare Card)

Address: _____
(Please provide the address and zip code you have on file with Medicare)

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **County:** _____ **Email:** _____

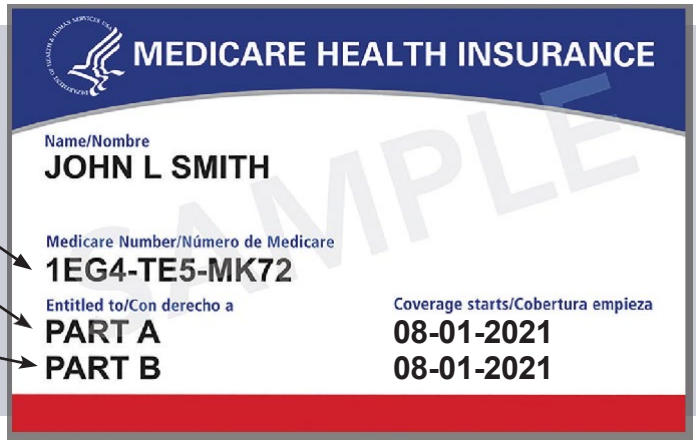
Do you live in NC year-round? ☐ Yes ☐ No **What is your primary language (if not English)?** _____

How did you learn about SHIIP? _____

What is YOUR Medicare Number?
_____

What is YOUR effective date for Medicare Part A?
_____

What is YOUR effective date for Medicare Part B?
_____



Do you currently have insurance coverage for prescriptions? ☐ Yes ☐ No

☐ Federal Employees Health Benefit Plan/TRICARE for Life/Veterans' Administration

☐ NC State Employee Health Plan ☐ Retiree Coverage

Please send my report to the family member/caregiver/etc. listed below:

Name: _____ Phone : (_____) _____

Address: _____

Relationship: _____ Email: _____

Are you interested in learning about Medicare prescription drug coverage available through:

☐ Medicare Stand-alone Prescription Drug Plans ☐ Medicare Advantage Plans (Medicare, HMOs, PPOs, PFFS, etc.)

In 2025, do you pay more than $12.15 for brand name drugs and $4.90 for generic drugs? ☐ Yes ☐ No

There are assistance programs available to help with prescription drug benefit costs.

Does your monthly income level fall below **$1,956**/single or **$2,644**/married (living together)? ☐ Yes ☐ No

Do your assets fall below **$17,600**/single or **$35,130**/married (living together)? ☐ Yes ☐ No

Please provide us with information about your prescriptions and pharmacy. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.

FULL NAME OF DRUG *(exclude OTC medications)*	**STRENGTH**	**DAILY DOSAGE**	**TABLET or CAPSULE?**	**FILL FREQUENCY**
Example: Lipitor	*Example: 10 mg.*	*Example: Twice Daily*	*"T" or "C"*	*Example: Every 30 days*

I currently have my prescriptions filled by Mail Order, or at this pharmacy _____

Please check all that apply:

☐ I would be willing to use a different pharmacy.

☐ I prefer to use a mail order pharmacy.

☐ I live in a Long-Term Care Facility.

NOTES

For office use ONLY

Username _____ Password _____

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