## 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 2021. 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.

Received _	
Appt date	
Counselor_	
Complete	

For office use:

ACL	
Data base	
Amount	
saved	

Please return this form to:

VICAP Central Virginia Alliance for Community Living or 501 12<sup>th</sup> Street, Lynchburg, Va 24504

Fax to 434-385-9209 email bbrickhouse@cvcl.org

1.	What is your Zip Code? MEDICARE HEALTH INSURANCE							
2.	What is your Medicare Number?							
	JOHN L SMITH							
3.	What is your Name?							
	1EG4-TE5-MK72  Entitled to/Con derecho a Coverage starts/Cobertura empieza							
	Last name HOSPITAL (PART A) 03-01-2016  MEDICAL (PART B) 03-01-2016							
	First Name							
4.	What is your effective date (when you first enrolled) for							
	edicare Part A?							
	Name/Nombre CALTH							
WI	hat is your effective date (when you first enrolled) for							
	edicare Part B?  Medicare Number/Numero de Medicare 1EG4-TE5-MK72							
	HOSPITAL (PART A) 03-01-2016  MEDICAL (PART B) 03-01-2016							
	MEDICAL (PART B) 03-01-2016							
5.	What is your Date of Birth?							
ı	Month Day Year							
6. <b>\</b>	What is your street address?							
8. I	In what County do you live? $\square$ Bedford $\square$ Campbell $\square$ Appomattox $\square$ Amherst $\square$ Lynchburg Cit							
9. ۱	What is your email address?							
7. \	What is your telephone number?							
	Please continue on the other side							

9. w	/hat Coverage do you now have?							
	☐ Medicare Prescription Drug plan							
	complete name of current plan   Medicare Advantage Plan							
	complete name of current plan							
	□ Virginia Medicaid □ other. I have							
40.1	_	-12						
10. 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.							
	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					
List 2	Please use addition  2 pharmacies you prefer using:	nal sheets if needed						
Phar	macy name Pharm	пасу пате						
eligil	are happy to help you regardless of your income, but one for extra help paying for your prescription drug	costs.	,					
is yo	ur monthly income and combined assets (other th		tnan:					
	<ul><li>☐ YES \$1615 income/\$14,600 assets if you live alone or</li><li>☐ YES \$2135 income/\$28,150 assets if you are married and living together?</li></ul>							