



For office use:

Received _____
Appt date _____
Counselor _____
Complete _____
ACL _____
Data base _____
Amount
saved

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

- | | |
|--|---|
|  MEDICARE HEALTH INSURANCE | |
| Name/Nombre
JOHN L SMITH | |
| Medicare Number/Número de Medicare
1EG4-TE5-MK72 | |
| Entitled to/Con derecho a
HOSPITAL (PART A)
MEDICAL (PART B) | Coverage starts/Cobertura empieza
03-01-2016
03-01-2016 |

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7. What is your telephone number? | | | | | | | | | | | | | | | | | | | | | |

9. What 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 _____

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:	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"
	Size example:500mg for pills, tablets; or 0.5 % for solutions or creams 2.0oz bottle or .5 oz tube	
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 paying for your prescription drug costs.

Is your monthly income and combined assets (other than your home and car) less than:

- ☐ YES \$1615 income/\$14,600 assets if you live alone or
- ☐ YES \$2135 income/\$28,150 assets if you are married and living together?