October 2017

Medicare Part D Worksheet

If you currently get your prescription drug coverage through TRICARE, VA benefits, Federal employee retirement benefits or any employer/ union retiree health plan, it is almost always best to keep that creditable coverage without any changes. You should contact your benefits administrator for information about your current benefits before making any changes.

If you do not have creditable retirement benefits, it is recommended that you review your Medicare options EVERY year. All Medicare patients can add, drop or switch their health and drug coverage during the Annual Coordinated Election Period. Other enrollment time frames may be available depending on your personal situation.

1. Do a Part D plan comparison online at www.medicare.gov
   Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day
   Or call OSHIIP at 1-800-686-1578
   Or complete this sheet and return it to OSHIIP
2. Check to see if you qualify for "Extra Help" to pay for some of your prescription costs
   Single: Income $1,528 per month; Total resources $13,820
   Married: Income $2050 per month; Total resources $27,600
   Apply online at www.socialsecurity.gov or call OSHIIP: 1-800-686-1578
3. The Annual Open Enrollment Period (OEP) is from October 15 – December 7.
   Any changes made during the OEP take effect January 1 of the following year.

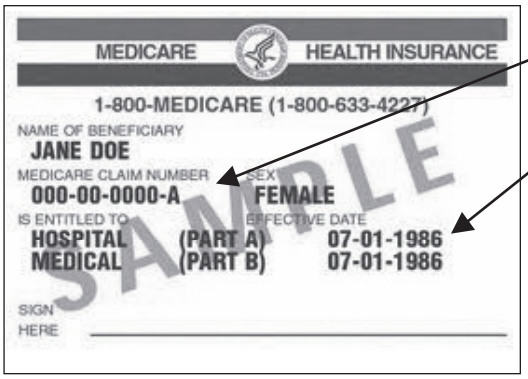
Please print clearly and answer all questions

Name: _____ Date of Birth: / /

Address: _____ County: _____

City/State/Zip _____ Phone #: -

Current Medicare Drug Plan: _____ E-Mail: _____



Medicare #: ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐

Medicare Effective Dates

Part A: ☐☐ - ☐☐ - ☐☐☐☐

Part B: ☐☐ - ☐☐ - ☐☐☐☐

Do you currently have coverage with: ____ Original Medicare or ____ Medicare Advantage

If enrolled in a Medicare Advantage plan, what is the plan name _____

Do you currently get assistance from: ☐ Medicaid ☐ QMB/SLMB/QI ☐ "Extra Help" with Part D

Do you want information on: ☐ Stand-Alone Part D plans ☐ Medicare Advantage plans (check one or both)

Please complete both sides of this form.

My Prescription Drug List

Preferred Pharmacy _____

Drug Name	Dosage (mg strength)	Frequency (times / day)
Ex: Lipitor	40 mg	1 per day

Return to: OSHIIP/ODI
50 West Town Street, 3rd floor
Columbus OH 43215

Fax: 614-752-0740
E-Mail: oshiipmail@insurance.ohio.gov
Phone 1-800-686-1578