



Medicare Part D Prescription Plan Worksheet

1-877-801-0044
www.tnmedicarehelp.com

Date: _____

The following questionnaire provides the necessary information that SHIP volunteers and staff need to prepare a comparison report . Once completed, please send to **TN SHIP, Andrew Jackson Building, 502 Deaderick Street, 9th Floor, Nashville, TN 37243**. You may also fax the form to **(615) 741-3309**. You will receive a personalized report in the mail regarding the most affordable plans in your area. TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan.

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 SSA)

City: _____ State: _____ Zip: _____

Phone: _____ County: _____

Email Address: _____

What is your Medicare Claim Number?

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What is your effective date for Medicare Part A?

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What is your effective date for Medicare Part B?

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Do you currently have insurance coverage for prescriptions? Yes No
If yes, check any that apply:

- Medicare Part D Plan (name) _____
- Medicare Advantage Plan (name) _____
- Medicaid
- Employer/Union Group Health Plan
- Federal Employee Health Benefit Plan
- TRICARE for Life
- Veteran's Administration
- Medigap/Medicare Supplement
- Other _____ (retirement, private, etc.)

