

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 \$1,581 per month; Total resources \$14,390
 Married: Income \$2,134 per month; Total resources \$28,720
 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 HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016

Coverage starts/Cobertura empieza

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: oshiiipmail@insurance.ohio.gov
Phone 1-800-686-1578