

Medicare Part D – Planfinder Tool



1-800-478-6065 • in Anchorage 269-3680

www.medicare.alaska.gov

The Medicare Information Office, a division in Senior and Disabilities Services of the Alaska Department of Health and Social Services, is able to help you find a Medicare Prescription Drug Plan that will meet your needs and assist you with enrolling in a plan. The following questionnaire provides the necessary information that staff and volunteer counselors need to be able to prepare a report for your consideration. This service is through Alaska's State Health Insurance Assistance Program (SHIP) -- it is objective and free of charge.

Once completed, please take the completed form to the counselor in your community or mail to

The Medicare Information Office 550 W. 8th Avenue Anchorage, AK 99501

Please provide us with contact information about yourself:

Name: _____

(Please provide your name as it appears on your Medicare Card)

Address: _____

(Please provide the address and zip code you have on file with Medicare)

City: _____ State: _____ Zip: _____

What is your Date of Birth: _____

What is your Medicare Claim Number? _____

What is your effective date for Medicare Part A? _____

What is your effective date for Medicare Part B? _____

A sample Medicare Health Insurance card for John D. Doe. The card has a red header with 'MEDICARE' and 'HEALTH INSURANCE' in white. Below the header is a blue bar with the Social Security Administration logo and the text 'SOCIAL SECURITY ACT'. The card contains the following information: NAME OF BENEFICIARY: JOHN D. DOE; MEDICARE CLAIM NUMBER: 123-45-6789A; SEX: MALE; IS ENTITLED TO: HOSPITAL INSURANCE (PART A) and MEDICAL INSURANCE (PART B); EFFECTIVE DATE: 1/1/95. There is a signature line at the bottom with a handwritten signature and the text 'SIGN HERE'.

Claim Number

Effective Date for Part A

Effective Date for Part B

Do you reside in Alaska year round? Yes No

Do you currently have insurance coverage for prescriptions? Yes No

If yes, please name your prescription drug plan and check any that apply?

Name of current prescription drug plan: _____

- Medicaid
- Alaska State Retiree Plan (AlaskaCare)
- Federal Employees Health Benefit Plan
- TRICARE for Life
- Indian Health Service benefits
- Veterans' Administration
- Medigap/Medicare Supplement
- Medicare Advantage Plan
- Other _____

Have you applied for Extra Help assistance? Yes No

Have you qualified for Extra Help assistance? Yes No

What type of deductible amount are you looking for in a Prescription Drug Plan?

\$310 annual deductible Reduced or zero annual deductible

Is having some coverage during the donut hole/gap period important to you? Yes No

I am interested in these companies/prescription drug plans only.

1. _____
2. _____
3. _____

Please provide us with information about your prescriptions and pharmacy. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.

NAME OF DRUG	STRENGTH	DAILY DOSAGE
<i>Example: Lipitor</i>	<i>Example: 10 mg.</i>	<i>Example: Twice Daily</i>

I prefer to have my prescriptions filled at this pharmacy(s) _____

- I would be willing to use a different pharmacy.
- I prefer to use a mail order pharmacy.
- I live in a Long-Term Care Facility.

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