OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Medicare Part D Rx Plan Finder worksheet

A free, unbiased service of the Washington State Office of the Insurance Commissioner, the Statewide Health Insurance Benefits Advisors (SHIBA) provides consumers with information about their Medicare Part D prescription drug options.

The following worksheet provides us with the necessary information we need to create a report for you. Once you complete the worksheet, please take it to a SHIBA Medicare Part D counseling clinic in your local county, or mail it to:

ENTER YOUR SHIBA SPONSOR
MAILING INFO LABEL HERE

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 Medicare.)

City: _____ State: _____ Zip: _____

Phone: (____) _____ County: _____ Email: _____

Do you live in Washington state year round?

☐ Yes ☐ No

What is YOUR Medicare claim number?

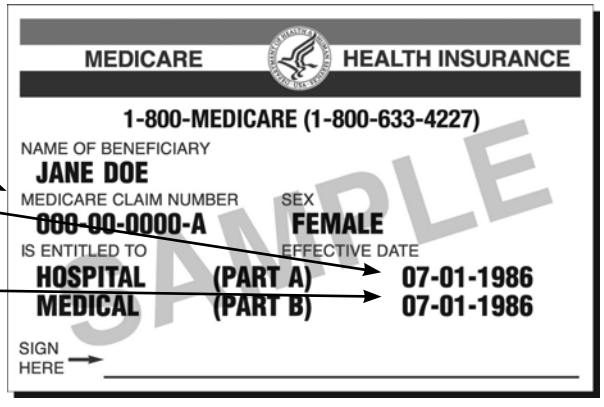
_____

What is YOUR effective date for Part A?

_____

What is YOUR effective date for Part B?

_____



Do you currently have insurance coverage for prescriptions? Check all that apply:

☐ Federal
☐ Employer's health plan
☐ Dept. of Veterans Affairs
☐ TRICARE for Life
☐ State of WA employee health plan
☐ Retiree coverage
☐ Other (please name): _____

Please send my prescription drug report to the following address:

Name: _____

Mailing address: _____

_____

Check if you're interested in either of following Medicare prescription drug coverage plans:

- ☐ Medicare Stand-Alone Prescription plans
- ☐ Medicare Advantage (MA) plans (Part C)
  NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

_____

_____

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than $1,500/single person and $2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? ☐ Yes ☐ No

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a ***COMPUTERIZED LISTING TO ATTACH***. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	**Strength**	**Daily dosage**
Example: Lipitor	*Example: 10 mg*	*Example: Twice daily*

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

_____

Please check all that apply:

- ☐ I'm willing to use a different pharmacy.
- ☐ I prefer to use a mail-order pharmacy.
- ☐ I live in a long-term care facility.

FOR OFFICE USE ONLY

Drug List Password ID# _____

Password Date _____ **Zip code** _____