Medigap Helpline and Medigap Prescription Drug Helpline

Board on Aging & Long Term Care.

The information given in this form will assist in providing a **Plan-Finder Comparison** for either a Medicare Advantage Plan or Medicare Drug Plan. Today's Date:_____

Name: Last:_____ First: _____
Last First

Phone (___) _____ Cell (___) _____

Email: _____

Mailing Address_____
Street City State Zip County

Date of Birth_____ Married_____ Single_____ Widowed_____

Contact Person: _____ E-mail: _____

Phone (____)_____Cell (____)_____Relationship_____

IMPORTANT: The more complete and accurate information that is provided the more accurate the estimates will be. This information will not be used for any other purpose nor will be shared with any other agency. Services will not be denied if financial information is not provided.

Enter your expected annual **gross income** (before taxes) for next year below.

Single:

Married:

Current information is important in generating a comparison. It may be helpful to take out insurance cards to verify this information. Indicate if have or are losing any of the following? (Click drop down for all that apply)

Medicaid: (Forward Health)	No	***Currently Receiving SSA Monies:***	No
LIS Extra Help	No	**Senior Care:**	No
Veteran Coverage:	No	Level of SeniorCare:	

Are you looking to change your coverage? No Annual Review of Your Plan: No

Reason for change_____

For office use ONLY: Counselor notes: MAPD PDP S/C PAP Coupons Counselor notes:

_____

_____

_____

_____

_____

_____

E-Mail completed form to: **boaltcrxhelpline@wisconsin.gov**

6/24 #81G.

First Name: **Zip Code:** **County:**

Current Coverage Information:

Medicare Drug Plan: *Name* _____ Monthly Premium $_____

Medicare Supplement: *Name* _____ Monthly Premium $_____

Medicare Advantage Plan: *Name* _____ HMO or PPO Premium $_____

Preferred Pharmacy (1) _____ (2) _____

Would you consider: Alternative pharmacies for cost savings? No

Mail order option if less expensive? No

Can generic alternatives be taken if available? No

Currently get assistance form a Pharmaceutical Assistance Program? No

The current medication list is important. A printout may be sent from the most recent doctor's visit or from the pharmacy. Be sure the amount purchased is listed on the info provided or fill in the chart below. Attach an additional page if needed.

INSULIN: enter the numbers of **vials or pens used in 1 month**
INHALERS: how many are **used each month**.

Medication FULL NAME **LIST ALL** current medications picked up at the pharmacy	**Dosage:** Caps or Tabs MG or MCG	**Amount** for each day	**Total #** Pills, Pens, Vials or Tubes (Size)/ **month**
Example: ***Metoprolol Succinate ER***	*50 MG ER*	*1 tab*	***30 tabs***
Example: ***Humalog mix 50/50 kwikpens***			***5 pens/month***

Other Notes / Additional Drugs