AREA AGENCY ON AGING
REGION ONE, INCORPORATED

SHIP State Health Insurance Assistance Program
Navigating Medicare

SMP Senior Medicare Patrol
Preventing Medicare Fraud

2024

MEDICARE DRUG OR ADVANTAGE PLAN COUNSELING TOOL

Get improved help with your Medicare choices by creating a Medicare.gov account:

Medicare is improving and modernizing the new Medicare *Plan Finder*, the tool the SHIP Benefits Assistance Program at the Area Agency on Aging uses to compare Medicare Prescription Drug Plans and Medicare Advantage Plans. To provide a personalized plan comparison, you will need to create a **MyMedicare.gov** account. The goal is to provide a seamless and transparent experience to help you get the information you need to make good health care choices.

Already have a **Medicare.gov** account	Don't have a **Medicare.gov** account yet?
User Name: _____ **Password**: _____ *This will be used to complete your 2024 Drug Plan or Medicare Advantage Plan comparison.*	Create your account at **Medicare.gov** and click "Log in or create an account" OR a SHIP counselor can help you create an account. *For a personalized plan comparison, you will need a MyMedicare.gov account.*
Authorization: I authorize the SHIP Benefits Assistance Program to use my Medicare.gov account to complete my plan comparison and or create an account if I don't have one. Signature: _____Date: _____	

Your name: _____ Date of Birth: _____

Your Address: _____City: _____ Zip: _____

Phone: _____Your email address: _____

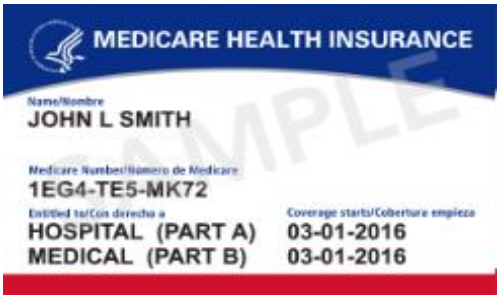
Gender: M ☐ F ☐ Your SHIP counselor name: _____

Please provide your Medicare number exactly as it is shown on your red, white & blue card that you received from Social Security:

Medicare Number:

_ _

_____



Start Date for:

Part A: _____/_____/_____

Part B: _____/_____/_____

Married? Yes ☐ No ☐ Total Gross Household Monthly income: $_____

Do you have savings or investments of more than $16,660 as a single person or $33,240 as a couple? Yes ☐ No ☐

Do you want a: Drug Plan ☐ or Medicare Advantage Plan ☐

Preferred pharmacy #1? _____

Preferred pharmacy #2?_____

Instructions: Give the complete name of each medication, including any suffixes, such as Hcl, ER, HFA, etc. Indicate whether drug is a tablet, capsule, ointment, etc.

	Name of Medication *Example: Metformin Hcl*	**Tablet, Capsule, etc.**	**Strength** *(10 mg)*	**Daily Dosage**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Information will be limited to only the ***top 3*** Drug Plans or Health Plans that meet your specific needs.

Results will be completed and given to you within 10 business days. Please indicate how you want to receive the results: email ☐ regular mail ☐
Send to: Area Agency on Aging, Region One, 1366 E. Thomas Road, Suite 108, Phoenix AZ 85014

The SHIP Benefits Assistance Program, does not recommend or endorse any drug plan or Medicare Advantage Plan and is not responsible for the service provided by these companies. Your information is confidential and will be securely stored in your SHIP file Revised: 09/15/2023