



2025

MEDICARE DRUG OR ADVANTAGE PLAN COUNSELING TOOL

Get improved help with your Medicare choices by creating a MyMedicare.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.

<p>Already have a MyMedicare.gov account</p> <p>User Name: _____</p> <p>Password: _____</p> <p><i>This will be used to complete your 2025 Drug Plan or Medicare Advantage Plan comparison.</i></p>	<p>Do not have a MyMedicare.gov account yet?</p> <p>Create your account at MyMedicare.gov and click "Log in or create an account" OR a SHIP counselor can help you create an account.</p> <p><i>For a personalized plan comparison, you will need a MyMedicare.gov account.</i></p>
<p>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 do not have one.</p> <p>Signature: _____ Date: _____</p>	

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 \$17,220 as a single person or \$34,360 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 <i>Example: Metformin Hcl</i>	Tablet, Capsule, etc.	Strength (10 mg)	Daily Dosage
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
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17				
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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