LOCAL HELP FOR PEOPLE WITH MEDICARE

Western Connecticut Area Agency on Aging

CHOICES MEDICARE PART D DRUG SCREENING FORM 2019

Notice: This is a request for a comparison of Medicare Prescription Drug Plans. You will not be enrolled into a plan until you contact us and request to enroll.

PLEASE FILL BOTH SIDES COMPLETELY AND RETURN TO CHOICES

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____

PHONE: _____CELL:_____

Please only CHECK WHAT APPLIES TO YOU:

_____ You are **NEW** to Medicare

_____You have Original Medicare

_____You have a Medicare Advantage Plan (HMO or PPO)

_____ The State pays your **Part B Premium**

_____ You have **both Medicare and Medicaid**

_____Your prescription plan is **NOT** covering all your medicine

_____You have **Veterans Benefits**.

_____You will no longer have creditable employer or retirement prescription insurance.

_____ You use mail-order pharmacy

_____ You have **retiree** insurance

TURN OVER

Please complete the other side of this form.
Married couples – please complete TWO separate forms.

Name of pharmacy you are planning to use: _____

Pharmacy address: _____

Name of your current plan: _____

*** Note: You MUST include at least one pharmacy to obtain a valid plan comparison
***Please PRINT the list of medications you take, use additional sheet if necessary.

Do NOT list over the counter meds

Prescription/Medication Name **Please check If it is a brand name or a generic name ⇨**	**Generic**	**Brand**	**Dosage** **(ML,MG)**	**Daily Quantity**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

PLEASE MAIL THIS FORM TO: **Western CT Area Agency on Aging**
84 Progress Lane 2nd Fl, Waterbury, CT 06705