Department of **Disability & Aging**

SHIP State Health Insurance Assistance Program — Navigating Medicare

SMP Senior Medicare Patrol — Preventing Medicare Fraud

2024 Medicare Part D Plan Comparison Worksheet

Jewish Federation OF GREATER CHATTANOOGA

This form provides the information we need to prepare your unbiased Medicare Part D comparison report. Please complete both sides entirely and return to us in the provided envelope. Once received we will contact you to schedule your appointment.

Name:_____ **Date of Birth:** ____/____/____
(As it appears on your Medicare Card)

Address: _____
(Please provide the address and zip code you have on file with SSA)

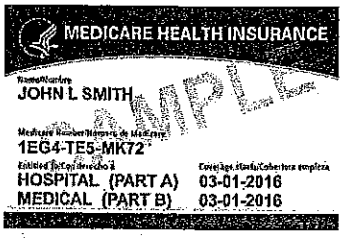
City: _____ **State:** _____ **Zip:** _____

Phone: _____ **County:** _____

Email Address: _____ **Gender:** ☐ Male ☐ Female ☐ Other

Medicare Number:	☐☐☐☐—☐☐☐—☐☐☐☐
Part A Start Date:	/ /
Part B Start Date:	/ /

Example:



Would like a personalized search and already have a Medicare.gov account? (Please provide account information) **User Name:**_____ **Password:**_____

Do you currently have any of the following insurances or assistance programs? (Check any that apply):

- ☐ Part D Prescription Drug Plans (list
- ☐ below) Medicare Advantage Plans (list
- ☐ below) Federal Employer Insurance
- ☐ Medigap/Supplement Insurance
- ☐ TRICARE or Veteran's Administraion
- ☐ Medicaid/TennCare
- ☐ QMB, SLMB, QI-1 (Medicare Savings Program *These pay your Medicare Premium*
- ☐ Low-Income Subsidy Program, "Extra Help" *Helps Lower Prescription Cost*

Please list your Part D Drug Plan or Medicare Advantage Plan information: (Plan ID usually begins with S or H)
Plan Name: _____ **Plan ID Number:**_____

Send me comparisons for:

- ☐ Part D Prescription Drug
- ☐ Plans Medicare Advantage

How would you like us to send your comparison?

☐ Postal Mail ☐ E-Mail ☐ Phone Call

Medication Information: *(Attach another page if needed.* ***Please do not include over-the-counter medications.*** *NOTE: If you take your medication as needed, please put how often you get it refilled as well as the quantity of the refill)*

Name of Medication	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)	Tablet/Capsule (T/C)	Quantity Per Day	***Refill Frequency

Other Medications (i.e. Inhalers, Insulins, Creams, Drops, etc.)

Name of Medication	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)	Size of Package	# of Packages per Refill	***Refill Frequency

List up to 5 Pharmacies you would like us to compare: (include mail-order if desired)

1. _____
2. _____
3. _____
4. _____
5. _____

Would you like us to contact you for low-income assistance? Please see the chart to the right for income guidelines:

☐ YES ☐ NO

Eligibility Criteria	Monthly Gross Income	Assets
Single	$1,882	$17,220
Married	$2,555	$34,360

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