LEBANON COUNTY AREA AGENCY ON AGING 08/06
MEDICARE PRESCRIPTION DRUG PLAN WORKSHEET

Beneficiary Name:	**Beneficiary Address:**
Representative Name:	
	Phone No.:
Zip Code of Counseling:	
Date of Birth:	**Gender:** ☐ Male ☐ Female
SSNumber: ☐☐☐ ☐☐ ☐☐☐	**Ethnicity/Race:**
Monthly Income:	☐ American Indian or Alaska Native
☐ Below $1225 person/$1650 couple	☐ Asian
☐ Above $1225 person/$1650 couple	☐ Black or African American
☐ Not Collected	☐ Hispanic or Latino
	☐ Native Hawaiian or other Pacific Is.
	☐ White, not of Hispanic origin
	☐ Not collected

Current Source of Prescription Drug Coverage:

- ☐ Medigap/Supplemental Insurance
- ☐ You or Your Spouse's Current Employer
- ☐ Retiree Coverage from a Union or Employer
- ☐ Veteran's Benefits
- ☐ Medicare Advantage Plan
- ☐ PACE/PACENET
- ☐ Private Insurance
- ☐ Medicaid
- ☐ Tricare
- ☐ No Drug Coverage

Medication Information

DRUG NAME	DOSAGE	30 DAY QUANTITY

Do you have a pharmacy preference? _____

This information is to compare plans only! It is not an enrollment form. You can obtain a paper enrollment form from the plan you choose, enroll directly on line or by calling **1-800-Medicare(1-800-633-42273).** APPRISE Counselors can assist with all enrollment methods.

I understand that APPRISE Volunteers have counseled and given advice to the best of their ability. I do not hold them liable for any misinformation.

Signature: _____ Date: _____