





## 2024 Medicare Part D Plan Comparison Worksheet

This questionnaire provides the information SHIP staff and volunteers need to prepare a comparison report. Once received, we will send you a personalized report on the most affordable plans in your area. TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan. The costs provided are estimates from the date the comparison was ran.

Please Mail completed form to: SHIP, Andrew Jackson Building, 9th Floor, 502 Deaderick St., Nashville, TN 37243.

For questions call 877-801-0044.

Name:		Dat	e of Birth://
As it appears on your Medicare Ca	ırd)		
Address:			
(Please provide the address and zip	o code you have on file with	h SSA)	
City:		State:	Zip:
Phone:		County:	
Email Address:		G	<b>fender:</b> ☐ Male ☐ Female ☐ Other
Medicare Number:			Example:  MEDICARE HEALTH INSURANCE
Part A Start Date:	/	/	Name/Nombre JOHN L SMITH  Medicare Number/Número de Medicare
Part B Start Date:	/	1	1EC4-TE5-MK72  Intitled bullcon directs a HOSPITAL (PART A) 03-01-2016  MEDICAL (PART B) 03-01-2016
account information) User Na	ame:	Pa:	ov account? (Please provide ssword:
	_		grams? (Check any that apply):
Part D Prescription D	_	Medicaid/Te	
below) Medicare Adv	_		QI-1 (Medicare Savings
below) Federal Emplo	oyer Insurance		ese pay your Medicare Premium Subsidy Program, "Extra Help"
Medigap/Supplemen		_	
TRICARE or Veteran's	Administraion	П	elps Lower Prescription Cost
Please list your Part D Drug F	Plan or Medicare Adva	antage Plan informatio	n: (Plan ID usually begins with S or H)
Plan Name:		Plan ID Number:	
Send me comparisons	for:	How would you like	us to send your comparison?
Part D Prescription D	)rug	Postal Mail	E-Mail Phone Call
Plans Medicare Adva	_		

Medication Information: (Attach	another page if needed.	Please do not include	over-the-counter m	edications. NOTE:
f you take your medication as needed,	please put how often yo	ou get it refilled as well as t	he 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
		n.			
Other Med	ications (i.e.	Inhalers, Insu	ulins, Crean	ns, Drops, etc.	)
Other Med	Generic OK?		Size of	-	***Refill
		Inhalers, Insu Strength/Dosage (mg, mcg, etc.)		ns, Drops, etc. # of Packages per Refill	
	Generic OK?		Size of	-	***Refill
	Generic OK?		Size of	-	***Refill
	Generic OK?		Size of	-	***Refill
	Generic OK?		Size of	-	***Refill
Name of Medication	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)	Size of Package	# of Packages per Refill	***Refill
Name of Medication  up to 5 Pharmacies you w	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency
Name of Medication  up to 5 Pharmacies you w	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc.)	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency
up to 5 Pharmacies you w 1	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc.)  4 5	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency
Name of Medication  up to 5 Pharmacies you w	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc.)  4 5	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency
up to 5 Pharmacies you w 1	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc.)  4 5	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency
up to 5 Pharmacies you w 1	Generic OK? (Y/N)	Strength/Dosage (mg, mcg, etc.)  compare: (inc.)  4.  5.  Eligibility (	Size of Package	# of Packages per Refill  der if desired)	***Refill Frequency