ServiceLink Resource Center
30 International Drive, Ste. 202
Portsmouth, NH 03801
603-334-6594

LOCAL HELP FOR PEOPLE WITH MEDICARE

ServiceLink Resource Center
8 Commerce Drive, Ste. 802
Atkinson, NH 03811
603-893-9769

I would like you to: ☐ Mail My Comparison *Or* I will call for an appointment and bring this worksheet

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

YOUR NAME

_____

MEDICARE CLAIM NUMBER

_____

IS ENTITLED TO:	EFFECTIVE DATE:
Hospital Part A	_____/_____/_____
Medical Part B	_____/_____/_____
DATE OF BIRTH:	_____/_____/_____

You may be eligible for extra help please check applicable box:

- ☐ I am single and my income is under $1,528 monthly
- ☐ I am married and our income is under $2,050 monthly
- ☐ I am already eligible for Extra Help
- ☐ I am not eligible for Extra Help

Your Address:

_____

_____

_____ Zip Code _____

Mailing address *if different*:

_____

_____

Your Telephone Number:

_____

Your EMAIL: _____

Are you a Veteran? YES NO

Preferred Pharmacy:

_____

Would you use a Mail Order option? YES NO

Would you like us to speak to someone else on your behalf about your Part D coverage?

If yes, whom?

_____

TURN THIS WORKSHEET OVER AND LIST ALL OF YOUR PRESCRIPTION MEDICATIONS

OFFICE USE ONLY- COUNSELOR COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

LIS Assistance Level: %_____
Helped Apply Online?
YES NO

Estimated Savings:
Cost Current Plan: $_____
Cost New Plan: $ _____
Estimated Annual Savings: $_____

Date Received:

Enrolled in Part D? YES NO
Plan Name: _____
Confirmation #_____

Plan Choices Provided: _____

DRUG LIST ID _____

PSWD DATE_____

LIST ONLY PRESCRIPTION MEDICATIONS. (NO OVER THE COUNTER, VITAMINS OR SUPPLEMENTS)

Name of Medication (Include ER, XR,HCL if applicable) * Indicates you require BRAND name medication ONLY	Strength/ Milligrams	Number of pills for *30* days supply

Insulin (Inform your Counselor if you have insulin PUMP please)

Name of Insulin (i.e. Lantus, Novolog,)	Pen *or* Vial Size (3ml/10ml)	Number of pens/vials for *30* days supply

Inhalers

Brand Name of inhaler (i.e. Sprivia, Proair, Advair. Include the strength of medication)	How do you take your inhaler? Nebulizer, Respimat, Canister.	Number of inhalers for *30* days supply

OTHER: Eye drops, Lotions, Creams, Gels

Name of Medication (Include strength,% or mg. Formulation i.e. lotion, gel, ointment)	Size of bottle/tube	Number of bottles/tubes for *30* days supply