LOG #
Date:

CY2022 Open Enrollment October 15 – December 7
Medicare Drug Plan Pre-Enrollment Information
SHINE Program at HESSCO (781) 784-4944, extension 254

Print Name: ______________________________ **Phone:**_______________**Date of Birth:**_____________

Address: ____
Street City Zip Code

Email address: _________________________________ **Marital Status:**________________________________

Medicare #*: __________________________________ **Effective Date**of Medicare A** _________**B:**__________
***As it appears on your Medicare card** ****As it appears on your Medicare card - Month & Year**

Do you have a Medicare.gov account?

→ **IF YES:** Username: _____________________Password: _________________________________

→ **IF NO: Please sign below to give SHINE permission to create and use a Medicare.gov account for you.**

(SHINE will assign: Username, Password, & Answer to a Secret Question)

Signature: ____

- -

Are you enrolled in any of the following supplemental insurance plans (medigaps), please check if yes:

Blue Cross/Blue Shield Medex:	☐ Bronze	☐ Sapphire	☐ Core
Health New England:	☐ Supplement 1	☐ Supplement 1A	☐ Core
United/ AARP:	☐ Supplement 1	☐ Supplement 1A	☐ Core
Fallon:	☐ Supplement 1	☐ Supplement 1A	☐ Core
Humana:	☐ Supplement 1	☐ Supplement 1A	☐ Core
Harvard Pilgrim:	☐ Supplement 1	☐ Supplement 1A	☐ Core
Tufts:	☐ Supplement 1	☐ Supplement 1A	☐ Core
☐ **VA Health Plan**	☐ **Other** ________________________________		

Do you have a Part D Drug plan? Yes___ No___ If yes, name of plan _____________________________________
OR
Do you have a Medicare Advantage (PPO or HMO) with RX plan? Yes___ No___
If yes, name of plan ____

Do you get reduced-cost or free prescription drugs through any State or Federal Program? Yes ____ No ____
If yes, name of program: ____

Are you enrolled in Prescription Advantage? Yes _____ No _____ No, but I have recently applied _____

PLEASE LIST YOUR PRESCRIPTION DRUGS ON THE BACK SIDE OF THIS FORM

For office use only	
Medicare.gov account established ☐ SHINE format ☐	Original cost New Cost
Counselor's Initials:	SAVINGS:

Pharmacy choice can impact your costs!

Would you change your pharmacy to save money? Yes ______ No _______
Which pharmacy do you currently use? ______________________________________
If Yes, please name specific pharmacies you would prefer to use:

____

Although it may not be the most cost-effective option, I only want to use mail order for my drug plan: Yes ______ No _______

Drug Name Example: Metoprolol Succinate Novolog FlexPen * **AS IT APPEARS ON THE BOTTLE:** IF YOU TAKE GENERIC LIST THE GENERIC NAME * **DO NOT LIST** VITAMINS, ASPIRIN, OR OTHER OVER THE COUNTER NON PRESCRIPTION ITEMS	**Drug Strength & Dosage** Example: 50 Mg. – one per day 8 Pens per month * **WRITE TABLET or CAPSULE, VIALS, TUBES, BOTTLES (with the size of bottle)** * **LIST MONTHLY QUANTITIES** * **PLEASE ESTIMATE HOW MANY AND HOW OFTEN INSTEAD OF USING "AS NEEDED".**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Please mail this completed form to:

Hingham Council on Aging
224 Central Street
Hingham, MA 02043