2021 Medicare Open Enrollment Screen Form

Please complete this form and return to the address below to get assistance with the Medicare Planfinder for Part D. All information provided is kept confidential.
If spouses are seeking screening for Part D, each needs to complete a separate form.

Name:_____

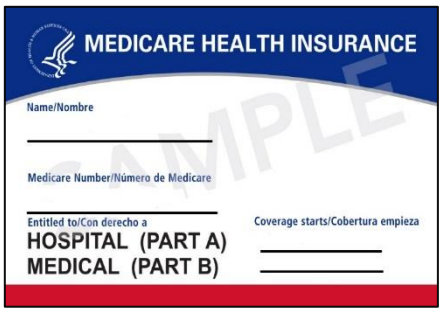
Phone Number: (___) _____ **Email :**_____

Street Address: _____

City: _____ **Zip Code**: _____

Date of Birth: _____

Marital Status: **Married** **Widowed** **Single**



Medicare Number:_____

Hospital (Part A) Start Date: _____

Medicare (Part B): Start Date:_____

Name of current Part D Plan: _____

Name of Current Health Plan OR Supplement Policy:

Are you enrolled in Medicaid? □ Y □ N

Do you have VA Drug Coverage? □ Y □ N

Are you enrolled in Seniorcare? □ Y □ N

#1 Pharmacy Choice: _____

#2 Pharmacy Choice: _____

Preferred method to discuss results:

Phone **Email** **In-Person (appts will be after Thanksgiving for in-person)**

******Please complete medication list on next page******

RETURN COMPLETED FORM TO: ADRC of the North- Bayfield County Branch Attn: Marianne

PO Box 100 Washburn WI 54891

Please attach a CURRENT list of prescription medications OR list current medications below.
***INCLUDE ALL MEDICATIONS- Including inhalers, injections,etc. Please note if the medication is taken as needed, and how often you fill the medication if not taken regularly.**
Attach separate sheet of paper if additional space is needed

Prescription Medication	Dosage	# of times per day	Type of Medication (Capsule, Tablet, Ointment, Lotion, Pen, Tube, Etc.)
Example: Simvastatin	**20 mg**	**1x**	**Tablet**

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