SHINE Program at HESSCO (781) 784-4944

Medicare Drug Plan Pre-Enrollment Information

Print Name: ___________________________ **Phone:**_________________ **Date of Birth:**__________

Address: ____
Street City Zip Code

Medicare #*:________________________ **Effective Date**of Medicare A** ___________**B:**___________
*As it appears on your Medicare card **As it appears on your Medicare card - Month & Year

Email address :__________________________________ **Married**____ **Widowed** ____ **Single** ____

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

Blue Cross/Blue Shield Medex Bronze: _____
Blue Cross/Blue Shield Medex Sapphire:____
Blue Cross/Blue Shield Medex Core: ______
Fallon Supplement 1: ____
Fallon Supplement 1A:____
Fallon Core: _____
Harvard Pilgrim Supplement 1: _____
Harvard Pilgrim Supplement 1A:____
Harvard Pilgrim Core: _____

Health New England Supplement 1: ______
Health New England Supplement 1A: _____
Health New England Core: _____
Humana Supplement 1: _____
Humana Supplement 1A: ____
Humana Core: ______
Tufts Supplement 1: ______
Tufts Supplement 1A: _____
Tufts Core: _____

United /AARP Supplement 1: _____
United /AARP Supplement 1A: _____
United/AARP Core: _____
VA Health Plan: _____ TRICARE: _____
Other – Name of plan/company: ______________

Are you in an employer retiree plan? Yes ____ No____ If yes, please provide information:

Name of Plan: ________________________ Does the plan provide prescription coverage? Yes ____ No ____

Do you have a Medicare Part D Drug plan? Yes___ No___ If yes, name of plan_________________

Do you have a Medicare Advantage (HMO or PPO) plan? Yes___ No___ Plan: ___________

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

Do you receive help with Medicare prescription drug plan costs? (LIS/Extra Help)? Yes ____ No ____

Are you enrolled in MassHealth? Yes _____ No _____

Note: There are benefit programs that might help with your health care costs. If you want us to check your eligibility, tell us your GROSS monthly income (you & spouse combined): $_____________

PLEASE LIST YOUR PRESCRIPTION MEDICATIONS ONLY ON THE BACK SIDE OF THIS FORM

For Office Use Only
MyMedicare Acct. Established on: _____________
by: Client: _____________ Shine: ______________
U: ____________________________________
P:____________________________________
General Search will be done: ___________
Counselor: ______________________________

For Office Use
Rec'd.________

What pharmacy do you use?___________________________________

Pharmacy choice can impact your costs. Would you change your pharmacy to save money? Yes ______ No _______

If yes, **NAME SPECIFIC PHARMACIES** you would use: ______________________________

I only want to use mail order with 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** * **DO NOT WRITE "AS NEEDED" AS A QUANTITY - ESTIMATE HOW MANY AND HOW OFTEN?**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

IF YOU HAVE AN APPOINTMENT WITH A SHINE COUNSELOR, PLEASE BRING THIS COMPLETED FORM ALONG WITH YOUR MEDICARE CARD TO YOUR APPOINTMENT

If not, please mail this completed form to:
HESSCO Elder Services
One Merchant Street, Sharon, MA 02067
Attn: SHINE Office