## **Nebraska SHIP & SMP Personal Information Worksheet**

Name:	Date of Birth:
Address:	County:
Mailing Address:	
City: Sta	ate: Zip Code:
Telephone Number: ()	MEDICARE HEALTH INSURANCE
Medicare Claim Number:	JOHN L SMITH
Part A Effective Date:	Medicare Number/Número de Medicare 1EG4-TE5-MK72 Entitled to/Con darecho a Coverage starts/Cobertura empieza HOSPITAL (PART A) 03-01-2016
Part B Effective Date:	MEDICAL (PART B) 03-01-2016
<b>Can you save on your N</b> If your income and assets fall within the be Ask your counselor fo	low range, you may qualify for Extra Help.
Individual: Monthly Gross Income: \$1,903 or less Assets: \$17,220 or less	<b>Married Couple:</b> Monthly Gross Income: \$2,575 or less Assets: \$34,360 or less

REVEN STOP Medicare FRAUD

**PREVENT** potential fraud and abuse by protecting your personal information. Do not share it with anyone you do not know.

**DETECT** fraud, abuse, or errors, by examining your Medicare Summary Notice (MSN) and Explanation of Benefits (EOB).

If you suspect potential fraud or have concerns, **REPORT** it to the Nebraska SHIP & SMP.

PREVENT Fraud and Abuse | DETECT Errors | REPORT Your Concerns

List the pharmacy you prefer to use	
Pharmacy Name:	Location:
Pharmacy Name:	Location:
Prescription drugs you are currently taking	
Your counselor will need a current list of your prescriptions inc do not have a list with you, please write them in the notes sect	
Read and sign below	
By signing below, I acknowledge that I am making my enrollment decision information from a counselor with Nebraska SHIP/SMP, the final decision understand that the counselor who assists me may be a volunteer and wi in my decision. I further understand that drug prices available on the wv subject to change. I hereby release any and all liability that may possibly agree not to pursue any legal action against the counselor and/or SHIP/SI counselor. I HEREBY GIVE SHIP/SMP, SHIP/SMP'S COUNSELOR(S) AND VOLUNTEER CREATION OF OR CREATE ON MY BEHALF A MEDICARE.GOV ACCOUNT. CONTAINS PERSONAL, IDENTIFIABLE HEALTH INFORMATION THAT I AM	will be made of my own free will and choice. I Il only provide me with information to assist me <b>vw.Medicare.gov are only an estimate and</b> be attributable to the volunteer counselor and MP for actions taken in their capacity as a <b>COUNSELOR(S) THE ABILITY TO ASSIST IN THE</b> <b>I FURTHER UNDERSTAND THAT THIS ACCOUNT</b>
SHIP TO ACCESS IN ORDER TO CREATE AND ACCESS THE MEDICARE.GOV	
Signature:	Date:
For SHIP/SMP Use:	
Volunteer Name:	Date:
Enrollment Completed: 🗌 Part D Plan 🗌 Medicare Advantage Plan	□ N/A

For SHIP/SMP Use:
Volunteer Name: Date:
Enrollment Completed: 🗌 Part D Plan 🗌 Medicare Advantage Plan 🗌 N/A
How is the Premium Paid: 🗌 SSA Deduction 🗍 Send Bill
Did I discuss MIPPA or SMP?
These enrollment documents are needed to claim the savings you've helped identify
<u>Old Plan Details</u> : Saved as PDF Paper <u>New Plan Details</u> : Saved as PDF Paper
Application Confirmation Page : 🗌 Saved as PDF 🗌 Paper
Reporting Needs:
Client Contact Form: Online - STARS (Enrollment documents uploaded) Paper (Enrollment documents attache
Notes:
OUT05142 " Revised 10/2024