Nebraska SHIP & SMP Personal Information Worksheet

Use this worksheet to help gather all the information you need to choose a Medicare drug plan that meets your needs. Please fill out as much of the information on this worksheet as possible.

Name: _____ Date of Birth: _____-_____-_____

Address: _____ County: _____

Mailing Address: _____

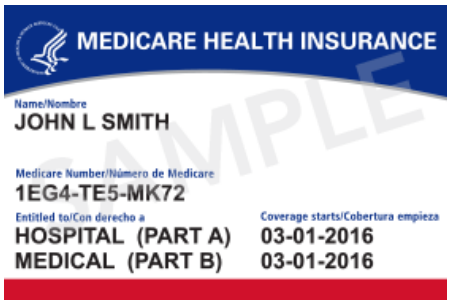
City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____-_____

Medicare Claim Number: _____

Part A Effective Date: _____-_____-_____

Part B Effective Date: _____-_____-_____



Can you save on your Medicare prescriptions?

If your income and assets fall within the below range, you may qualify for Extra Help.
Ask your counselor for more information.

Individual:
Monthly Gross Income: $1,903 or less
Assets: $17,220 or less

Married Couple:
Monthly Gross Income: $2,575 or less
Assets: $34,360 or less

Did you know fraud costs Medicare billions of dollars each year and damages the Medicare program. It is vitally important to root out fraud, and Medicare needs your help!

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 including name, dosage, and quantity. If you do not have a list with you, please write them in the notes section below.

Read and sign below

By signing below, I acknowledge that I am making my enrollment decision freely and voluntarily. While I may receive information from a counselor with Nebraska SHIP/SMP, the final decision will be made of my own free will and choice. I understand that the counselor who assists me may be a volunteer and will only provide me with information to assist me in my decision. **I further understand that drug prices available on the www.Medicare.gov are only an estimate and subject to change.** I hereby release any and all liability that may possibly be attributable to the volunteer counselor and agree not to pursue any legal action against the counselor and/or SHIP/SMP for actions taken in their capacity as a counselor.

I HEREBY GIVE SHIP/SMP, SHIP/SMP'S COUNSELOR(S) AND VOLUNTEER COUNSELOR(S) THE ABILITY TO ASSIST IN THE CREATION OF OR CREATE ON MY BEHALF A MEDICARE.GOV ACCOUNT. I FURTHER UNDERSTAND THAT THIS ACCOUNT CONTAINS PERSONAL, IDENTIFIABLE HEALTH INFORMATION THAT I AM ALLOWING, FOR THE PURPOSE STATED ABOVE, SHIP TO ACCESS IN ORDER TO CREATE AND ACCESS THE MEDICARE.GOV ACCOUNT.

Signature: _____ Date: _____

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? ☐ MIPPA ☐ SMP

These enrollment documents are needed to claim the savings you've helped identify.

Old Plan Details : ☐ Saved as PDF ☐ Paper New Plan Details : ☐ Saved as PDF ☐ Paper

Application Confirmation Page : ☐ Saved as PDF ☐ Paper

Reporting Needs:

Client Contact Form: ☐Online - STARS (Enrollment documents uploaded) ☐Paper (Enrollment documents attached)

Notes: _____

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