Nebraska SHIP 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.

Complete the following personal information

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

Address: _____ County: _____

Mailing Address: _____

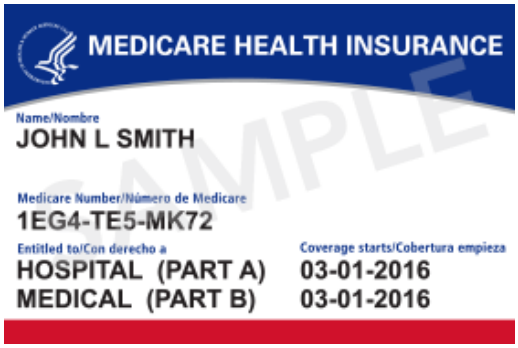
City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____-_____

Medicare Claim Number: _____

Part A Effective Date: _____-_____-_____

Part B Effective Date: _____-_____-_____



If your income and assets fall within the below range, you may be able to save money on your prescriptions. Just ask your counselor for more information.

Individual:
Monthly Gross Income: $1,843 or less
Assets: $16,660 or less

Married Couple:
Monthly Gross Income: $2,485 or less
Assets: $33,240 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!

PROTECTING your personal information is the best line of defense in the fight against Medicare fraud and abuse. Do not provide your personal information to anyone you do not know.

DETECT fraud by examining both the Medicare Summary Notice (MSN) you receive from Medicare and the Explanation of Benefits (EOB) you receive from your Part D or Medicare Advantage Plan.

If you suspect fraud in your healthcare,
REPORT IT to the Nebraska SHIP/SMP!

PROTECT *Personal Information* | **DETECT** *Fraud and Scams* | **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, 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 for actions taken in their capacity as a counselor.

I HEREBY GIVE SHIP, SHIP'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 Use:

Volunteer Name: _____ Date:_____

Enrollment Completed: ☐ Part D Plan ☐ Medicare Advantage Plan ☐ N/A

How is the Premium Paid: ☐ SSA Deduction ☐Send Bill

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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