

Medicare Part D Worksheet

Medicare beneficiaries are allowed to select a Medicare prescription drug plan (1) when first enrolling in Medicare, (2) if you move, and (3) again every year between October 15th and December 7th. You should compare insurance plans every year because the coverage changes every calendar year.

The Rappahannock Area Agency on Aging Part D Counseling Program will help you compare plans and choose the best plan for your needs on a space-available basis. You may find it helpful to gather your prescription drug bottles and your Medicare card before filling out this worksheet.

PRINT or TYPE		
1. First Name:	Last Name:	M.I
2. Address:		
3. Zip Code:		
5. Telephone: Home No		
Cell No		
6. Medicare Claim Number:		MEDICARE HEALTH INSURANCE
Part A:	(mm/dd/yy)	1-800-MEDICARE (1-800-633-4227)
Part B:	(mm/dd/yy)	JANE DOE
7. Date of Birth:	(mm/dd/yy)	MEDICARE CLAIM NUMBER SEX - (000-00-0000-A) FEMALE
8. What type(s) of prescription	drug coverage do you have now?	IS ENTITLED TO EFFECTIVE DATE
(Check all that apply)		HOSPITAL (PART A) 07-01-1986 MEDICAL (PART B) 07-01-1986
 Medicare Prescription 	Drug Plan (PDP)	Parametrica Alexandria Caracteria
Name o	f Plan:	HERE - Jane Doe
o Medicare Advantage Pl	an (HMO, PPO, PFFS)	
Name o	f Plan:	

Mobility Options: (540) 656-2985

None of the above

Employer or Union Retiree Plan

Currently working and have employer sponsored health insurance

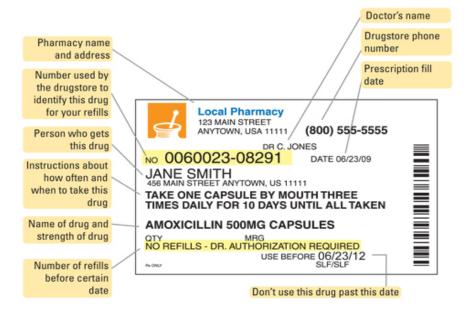
Phone: (540) 371-3375 Fax: (540) 371-3384 www.raaa16.org

Medicaid

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Main Office:
460 Lendall Lane, Fredericksburg, VA 22405
A UNITED WAY AGENCY

Our Service Area: City of Fredericksburg Caroline County King George County Spotsylvania County Stafford County



Please PRINT:

- The complete Name of your prescription drugs (do not list over the counter drugs, vitamins, or supplements)
- The Strength of each drug (for example 50 mg or 250 mg)
- How much (Quantity) you buy for one month number of pills, bottles, tubes, inhalers per month.
- For liquids, eye drops, creams, inhalers, insulin pens, etc. please give the size of the container and the number of containers you buy for 30 days (one month)

Prescription Drug	Dosage (ex:10mg)	Number taken daily	Quantity per month
Name (ex: lisinopril)		(ex: twice daily)	(ex: 30 pills)
Lisinopril	10mg	Twice a day	60 pills

Please list your preferred pharmacy.		
1st Pharmacy:	City	Zip Code
2nd Pharmacy:	City	Zip Code

The VICAP team will assist you by preparing an analysis of your Part D options.

Return the work sheet in one of the ways listed below.

Mail or Drop-Off: VICAP Team-RAAA

460 Lendall Lane Fredericksburg, VA 22405

Email information to: Medicare@raaa16.org

FAX: 540-371-3384 Attention: Medicare Part D

When your analysis is complete, the VICAP team will contact you to set an appointment to discuss your options.