

MEDICARE PART D WORKSHEET

All information provided is kept in the strictest confidence

Supplying us with this information will allow us time to carefully determine which Medicare Part D plans will work best for you.

You may be eligible for a program to reduce the cost of your Medicare premium and/or copays. If you would like more information, please ask us. You will need to provide information about your income and assets.

NAME

ADDRESS

TELEPHONE

AGE

DATE OF BIRTH

SS#

MEDICARE #

MEDICARE PART A DATE:

PART B DATE:

#1 Pharmacy Choice

City

#2 Pharmacy Choice

City

Current Health Plan

Current Prescription Plan

Primary Physician

Address

When you have completed this form, both front and back, mail to:

Aging and Disability Resource Center-Iowa County

Benefit Specialist Office

222 N. Iowa Street

Dodgeville, WI 53533

608-935-0389



