



LOCAL HELP FOR PEOPLE WITH MEDICARE

Oklahoma Insurance Department

Assistance to find a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Plan (including a Drug Plan) (MAPD).

All information provided will remain CONFIDENTIAL.

Senior Health Insurance Counselors will use your data to retrieve plan information from www.Medicare.gov. This information will provide you with a list of PDPs or MAPDs in your area, and will outline the three least expensive insurance policies.

This list will be sent to you via US Mail for your personal use. If you have any questions regarding the information you receive, please contact the Senior Health Insurance Counseling Program at (800) 763-2828.

You must provide us with all of the information below in order for our Counselors to process your request.

ZIP Code: _____ County: _____

Medicare Number: _____ - _____
(you will find this number on your RED/WHITE/BLUE Medicare Card)

Last Name: _____

Part B Effective Date: _____
(you will find this number on your RED/WHITE/BLUE Medicare Card. If you do not have your Part B effective date, write Part A on the line provided and the Part A effective date)

Date of Birth: _____ - _____ - _____

Do you have a PDP or MAPD right now? Yes ___ No ___ Which one? _____

Do you receive Extra Help to pay your prescriptions from Social Security? Yes ___ No ___

Local Pharmacy Name: _____

Pharmacy Address: _____

Information About You....

(This information is needed to send you our results, as well as for reporting purposes.)

Home Street Address: _____

Home Phone Number or Cell:(_____)_____ - _____

How did you hear about our assistance services (Senior Health Insurance Counseling Program)? _____

What is your race-ethnicity? _____

Is your monthly social security bank deposit is \$1,218.38/month if single or \$1,639.13/month if married? Yes_____ No_____

Do you receive any other income? Yes_____ No_____

If yes, please list the source and the monthly amount received:

Source	Amount per Month
Example: Rental Property	\$500.00
_____	_____
_____	_____
_____	_____
_____	_____

Would you like a Counselor to call you about receiving Extra Help for prescription drug coverage? Yes_____ No_____

Are you receiving Social Security Disability? Yes_____ No_____

If yes, are you eligible for Mental Illness Disability? Yes_____ No_____

