MEDICARE OPEN ENROLLMENT October 15th to December 7th

Pre-Enrollment Form 2024

Bring this completed form to your appointment. If you do not have this completed form, your appointment may be rescheduled.

Name: **Date of Birth:**

Address:

City: **State:** **Zip:**

Phone: ( ) **County:** **Year-Round Resident? ☐ Yes ☐ No**

Email Address: **Primary Language:**

How did you hear about us: **Beneficiary Age:** **Gender:** **Race:**

Have you or immediate family member served in the military? ☐ Yes ☐ No
I am interested in reviewing my Part D Drug Plan? ☐ Yes ☐ No Advantage Plan? ☐ Yes ☐ No
Do you have a Supplement? ☐ Yes ☐ No Are you happy with your supplement? ☐ Yes ☐ No
Do you currently have other insurance coverage? ☐ Yes ☐ No If yes, Which? _____

Have you established a Medicare.gov account?
If YES, make sure you have your login and password information available.
If NO, make sure you have your Medicare Card information available.

Medicare Card Information

Name:

Number:

Part A effective Date:

Part B effective Date:

Medicare Account Information

☐ I Prefer NOT to share this Information, but I will have this information with me.

Username:

Password:

Security Question:

Answer:

Income/Subsidy Information

Does your Monthly Income fall below $1,822.50 ($21,870 annually) for Single or $2,465 ($29,580 annually) for Married couple? ☐ Yes ☐ No

Do your Resources/Assets fall below $16,600 Single or $33,240 Married? ☐Yes ☐ No

Are you currently receiving? ☐ Extra Help

☐ Medicaid ☐ Medicare Savings Plan

Pharmacy Information

What is your Preferred Pharmacy?_____

Alternative Pharmacy?_____

Do you use Mail Order? ☐ Yes ☐ No

Are there any Medications that are not covered by your current plan? ☐ Yes ☐ No

List: _____

Please provide us with information about your prescriptions and pharmacy.

NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach.

If not, Please complete the chart below. Please attach additional sheets if needed.

Name of Drugs	Strength	Daily Dose
Example: Lipitor	*Example: 10 mg.*	*Example: Twice Daily*

Do you have any problems, comments, or concerns you would like to discuss?

Appointment Preferences:

I prefer ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time _____

Will you need a Spanish speaking interpreter? ☐ yes ☐ no

I would prefer a ☐ Meet in person at Pittsboro Center ☐ Siler City Center ☐

at Piedmont Health ☐Moncure Clinic or ☐Siler City Clinic

Or Phone conference ☐

I have a computer at my home that I can use. ☐ yes ☐ no

I am comfortable with the computer ☐ yes ☐ no

I have internet at my home ☐ Yes ☐ no I have an active email account? ☐ Yes ☐ No

FOR OFFICE USE ONLY: Appointment Scheduled for: Date:_____Time: _____

☐ Phone ☐ Video ☐ In-person Sent Comps, Materials, Link ☐ Mail ☐ Emailed ☐ Fax Date_____