Medicare Annual Open Enrollment Form

October 15 – December 7

All Information provided is kept confidential.

*****Required: Must be fully completed and returned to receive a comparison*****

Name: _____ Date of Birth: _____/_____/_____

Address: _____

City/Town: _____ Zip Code: _____

Phone: _____ Marital Status: _____

Have you qualified for Medicare Savings Program? □ Y □ N

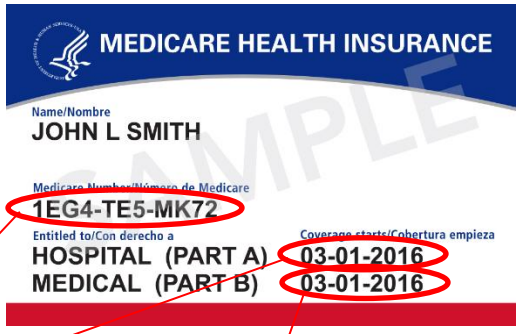
Do you have coverage through your employer? □ Y □ N

Are you enrolled in Medicaid? □ Y □ N

Do you have VA Drug Coverage? □ Y □ N

Are you enrolled in SeniorCare? □ Y □ N

Do you receive Extra Help (LIS)? □ Y □ N



Medicare Number _____

Coverage Start Date: Part A _____/_____/_____ Part B _____/_____/_____

Preferred Pharmacy 1) _____ 2) _____

Do you fill prescriptions by mail order? ____ Yes ____ No

Provide the following information:

Complete name of your health insurance plan as printed on your insurance card
Complete name of your Medicare Part D Prescription Drug Plan, as printed on your card

***Please note:** Not all comparisons require an appointment and to assist the largest number of Columbia County residents we may mail the results of your comparison.*

Please choose:

□ Mail my comparison □ Notify me when my comparison is ready for pickup

If an appointment is needed, which do you prefer?

□ Phone appointment □ In-person appointment

On the second page, please list all your prescription medications.

List All Your Prescription Medications

- **Over the Counter** – No need to include on this list
- **Insulin** – list # of bottles per month, for insulin pen or pump list # of cartridge refills per month
- **Inhalers** – list # per month
- **Eye Drops** – list # of bottles per month

Complete Drug Name *Example: (Metoprolol Tartrate)*	Type *(TAB or CAP)*	Strength *(10 mg)*	Dosage *(2/day)*	Frequency of Refill *(30/60/90 Days)*

Completed forms MUST be received by November 15th.
Please mail or drop off to:
Columbia County ADRC.
PO Box 136
111 E. Mullett St.
Portage, WI 53901