COLUMBIA COUNTY
Aging and Disability Resource Center

608-742-9233
888-742-9233
FAX: 608-742-9277
TDD: 608-742-9229
E-MAIL: ADRC @columbiacountywi.gov
WEBSITE: www.co.columbia.wi.us

111 E Mullett St.
P.O. Box 136
Portage, WI 53901-0136

Each year from October 15th through December 7th, during Medicare's Open Enrollment Period, you have an opportunity to review and change your Medicare Part D Plan or Advantage Plan for the following year. It is important to review your plan each year to make the right choices for your healthcare.

Please note that Medicare Supplements and SeniorCare are not affected by this enrollment period. If you are on SeniorCare and have had medication changes, you might want to check on the cost of other Medicare plans to see if SeniorCare is still the best option for you.

This year I will be meeting with clients in person, via the phone or by mail. During this busy time of year my availability is limited.

NEW IN 2024 I will be prioritizing appts by:

1. Medicare Part D/Senior Care
    a. *Changes can only be made from 10/15 - 12/7 for 1/1/2025 change.*
2. Medicare Advantage Dual Special Needs Plans (Medicare & Medicaid)
    a. *Changes made from 10/15 – 12/7 for 1/1/2025 change.*
3. Medicare Advantage Plan
    a. *Changes can be made BOTH from 10/15-12/7 and 12/1/25 - 3/31/25.*

If you would like me to review your 2025 plan options, please complete the enclosed forms and return them by **November 15, 2024, or as soon as possible**. Once I receive your information, I will reach out to make an appointment.

Please know that you can also contact:

- The Board on Aging & Long-Term Care Part D Helpline at 1-855-677-2783 or
- Medicare at 1-800-633-4227 for assistance.

Sincerely,

Kathy Cummings

Kathy Cummings
PO Box 136
111 East Mullett Street
Portage, WI 53901
(608) 742-9210
kathleen.cummings@columbiacountywi.gov

Medicare Annual Open Enrollment Form

October 15 – December 7

All Information provided is kept confidential.

*****Completed form required to schedule appointment*****

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

Address: _____

City/Town: _____ Zip Code: _____

Phone: _____ Marital Status: _____

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

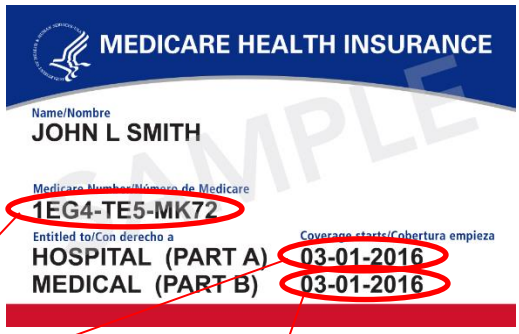
Do you have coverage through your employer? □ Y □ N

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 _____/_____/_____

(On your red, white & blue Medicare card)

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

Have you created a MyMedicare Account? If not, see separate instructions included in mailing.

******We will input your information to compare your option for 2025******

Please select one of the following:

□ Please mail my comparison for my review. If I want to make changes or have questions, I will call to set up a telephone or virtual meeting.

□ Please call me to schedule an in person to go over my comparison.

On the second page, please 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)*

RETURN COMPLETED FORMS TO:
ADRC OF Columbia County
PO Box 136
Portage, WI 53901

Medicare Advantage/Part D Plan Disclaimer

Client Name(s): _____

I have requested the Elder Benefit Specialist's assistance discussing my options for a Medicare Advantage or Part D plan.

I understand that the accuracy of the Medicare Planfinder depends upon the information given to the Center for Medicare and Medicaid services, which is provided by the plans, as well as information I have provided to the Elder Benefit Specialist regarding my medications. **The Medicare website is subject to revision and/or error, and <u>is not a guarantee of pricing or formulary coverage</u>. It is solely the best guess estimate from the plan and pricing can fluctuate.**

☐ I have been informed that the most accurate information is available by contacting the plan directly.

The Elder Benefit Specialist's enrollment assistance into a plan is <u>not</u> a recommendation as to which plan is best for me. I have selected the plan that I believe best suits my needs and budget. I take full responsibility for this choice.

I understand that any and all follow-up matters with this plan are my responsibility. If I have reason to believe that the enrollment did not go through for some reason, I will notify the plan and the Elder Benefit Specialist immediately. **I understand that all enrollments must be made by December 7, 2024.**

I acknowledge that participants can generally only change plans once per year during the Annual Enrollment Period. By enrolling in this plan now, I understand that, absent a special enrollment period, I will probably have to stay in this plan for a year before I can drop or switch plans again.

☐ I will enroll myself.
☐ I request enrollment assistance into _____ (name of plan)

_____ _____
Client (s) signature Date

_____ _____
Elder Benefit Specialist Signature Date

MyMedicare Online Account Disclaimer

We are highly encouraging all participants enroll in MyMedicare to assist the Elder Benefit Specialist in determining the most cost-effective Part D or Advantage plan. Your account will be kept confidential. Usernames and Passwords are kept in your paper file only, not stored electronically.

By signing this form, I request the Elder Benefit Specialist's assistance in creating/ gaining access to a **MyMedicare** account online, in order to obtain a personalized plan comparison. I understand my username and password will be kept in my secure file and neither the EBS nor the ADRC will use my username and password to access my MyMedicare.gov account without my permission.

I understand that I have the right to request a copy of my username and password at any time, and I have a right to change my username or password at any time. I understand that I have the right to revoke this consent at any time by contacting the ADRC at (608)742-9233 or the EBS at (608)742-9210.

_____
Client Name

_____ _____
Client Signature Date

**If have already have a MyMedicare on-line account we would appreciate if you would share the Username and Password with us during our appointment so we can use the most accurate information when doing plan comparisons.*

_____
Username

_____
Password

Permission was obtained by: Face to Face or Phone Call