2 Industrial Park Drive, PO Box 1016, Concord, NH 03302
Phone: 603-228-6625 Fax: 603-228-6623
info@mcservicelink.org

Medicare Open Enrollment Form

Name: ____ **Phone:** ____________________

Mailing Address: ____

Your Pharmacy: ____

Email address: ____

Medicare Number: ____________________________ **Date of Birth:** ____________________

Effective Dates: Part A: _______________ **Part B:** _______________

Financial assistance, known as "extra help", for your plan premium and your medications may be available.
Monthly gross income limit: $1538 (single), $2078 (couple) **Resource limit**: $14,100 (single), $28,150 (couple)
☐ I'm already approved for "extra help" ☐ Please help me apply for "extra help" ☐ I'm over income/resources

Prescription **Medication name (**ex. Lipitor**)**	**Can you take generic?**	**Strength (**ex. 20 mg.**)**	**Dosage:** how many pills per day/vials each month
Name of Insulin (i.e. Lantus, Novolog)		**Pen or Vial size (3ml/10ml)**	**Number of pens/vials for 30 day supply**
NOTE: Medications administered through your Nebulizer are covered by Part B-medical			
Need more space to list your medications? Attach another sheet of paper with additional items.			

I give permission for ServiceLink staff to discuss my medication list with providers as necessary and to enroll me in my chosen plan.

Your signature: ______________________________ ***Date:*** ____________

This Side For Office Use Only

DATE RECEIVED STAMP

Initials: __________

Appointment: ____________________________

Advantage plan? Y / N (circle one)

Counselor: _____________________________

Drug list entered: ____________ ________
(date) (staff initials)

Refer Record #:______________________________

Spouse's name: __________________________________ Refer #_____________

Drug list ID: __________________________

Password / DOB: ___________________________

LIS application date:________________ Re-entry #_________________

Annual Cost Savings

Old Plan annual cost: _$_______________ **Name:**______________________________________

New Plan annual cost: _$_______________ **Name:**______________________________________

Annual savings w/ switch: _$_______________

Disclaimer

ServiceLink is not connected with any insurance company; we are not here to sell you any insurance plan. We offer help in comparing Medicare options, including supplements, Part D prescription plans, and Medicare Advantage plans. Assistance is provided to the best of our ability by trained staff and volunteers with the information we have from the Center for Medicare and Medicaid Services (CMS). It is your choice to enroll in a plan or not and you can choose to make decisions without our help.

Personally identifiable information will be exchanged electronically with other providers of health care and insurance in order to complete enrollment in Medicare plans. This information will be shared according to the Health Insurance Portability Accountability Act (HIPAA).

I understand this disclosure and choose to accept Medicare counseling from ServiceLInk staff and volunteers. I will not hold ServiceLInk, its employees or volunteers responsible for any decision I make about my Medicare insurance choices.

Client Signature: ____ Date: _________________________

Or: Phone review with client: _________
(staff initials)