Medicare Medicaid Assistance Program – MMAP
(231) 775-0133
Medicare Prescription Drug
Personal Information Worksheet

Using your Medicare Health Insurance Card (the red, white and blue card), please furnish the following information:

Medicare Claim Number: _____
(Usually your social security number plus a letter)

Name (first, last): _____
(Name as it appears on your Medicare Card)

Date of Birth: _____ (Month, Day, Year) **Phone Number:** _____

Effective Date of: Medicare Part A _____ (Month, Day, Year)

Medicare Part B _____ (Month, Day, Year)

Address: _____
Street City State Zip

County: _____ **E-mail:** _____

Social Security Number: _____

1. **If you currently health and drug coverage please indicate the type and the name of plan:**
   ☐ **Medicare Drug Plan** ☐ **Medicare Advantage Plan** ☐ **Employee Retirement Health Plan** ☐ **None**
   What is the name of your current drug plan? _____
2. **Are you currently enrolled in the Blue Cross Blue Shield Legacy Plan?** ☐ **Yes** ☐ **No** ☐ **Not sure**
3. **Do you have "Extra Help" from Social Security to lower the cost of your Medicare prescription drug premiums and your drug co-pays?** ☐ **Yes** ☐ **No** ☐ **Not Sure**
4. **If you get "Extra Help" please indicate the percent of help received.** ☐ **100%** ☐ **75%** ☐ **50%** ☐ **25%**
5. **Depending on your income and assets, you might be eligible for low income assistance. If you are interested in being screened for these benefits please furnish the following:**
   Your gross monthly income before deductions (include Social Security, Pension, etc.): **$**_____
   If you are married, what is the total monthly income for your spouse: **$**_____
   Joint cash assets for both spouses (including savings, checking, CD's, 401K, IRA, etc.): **$**_____
6. **List your preferred Pharmacy or indicate if you want to receive your medications via mail order:**
   _____ **Mail Order** ☐ **Yes** ☐ **No** ☐ **Maybe**
   Name of Pharmacy City, State

For Agency Use:			
Counselor:	Plan Year(s):	Date Sent:	Date Received:

******Please list your medications on the back of this form******

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LIST YOUR DRUGS ON THIS PAGE

1. Using your **prescription container**, list the full name of each drug.
2. If your prescription is for a **generic medication**, make sure you list that name also.
3. List the **dosage** AND how often you take the medication **each day** along with the **monthly usage quantity.**
4. Make sure that the information is written legibly.

Drug Name	Dosage	Frequency per Day	Monthly quantity of pills, vials, packages, inhaler, etc.

PLEASE RETURN THIS FORM TO:

Wexford County Council on Aging
714 W. 13th Street
Cadillac, MI 49601
(231) 775-0133

If you prefer to find a drug insurance plan yourself you can use the plan finder located at www.medicare.gov
OR
You can call Medicare at 1-800-633-4227 (1-800-MEDICARE) for assistance