# Wexford COA - MI Options
# (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:**

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

**Medicare Number** _____

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

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

Medicare Part B _____ (Month, Day, Year)

**Address:** _____
Street City State Zip

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

**If you currently have drug coverage, please indicate the type and the name of the plan:**

☐ **Medicare Drug Plan** ☐ **Medicare Advantage Plan** ☐ **Employee Retirement Health Plan**

**Name of plan** _____

**If you know your Medicare.gov username/password list here. Username:** _____ **Password:** _____

**Do you use manufacturer or pharmacy discount programs? If yes, please indicate** ☐ **Yes** ☐ **No** _____

**Do you receive any of medications from VA, a free clinic or directly from your Dr. office?** _____

**Do you have a Medication exception with your current plan? If so, please indicate.** _____

**List top 3 preferred pharmacies including the City and State.**

**1.**_____ **2.**_____ **3.**_____

**You could qualify for Medicare Extra help programs, depending on your material status, gross income and assets.**

**If interested, please indicate if you are single, married, and your gross income.** ☐**Single** ☐ **Married, Gross Income$**_____

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

**PLEASE RETURN THIS FORM TO:**

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

Revision Date: 08/21/2025

| *For Agency Use: Plan Year(s): 2026* | | | |
|---|---|---|---|
| Counselor: | Two-Step Auth | Yes / No | Date Received: |

**LIST YOUR DRUGS ON THIS PAGE**

**(Please print clearly) – Already have a Medication List, attached a Copy!**

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 the generic name also.
3. List the **dosage AND** how often you take the medication **eac** g with the **monthly usage quantity.**
4. Make sure that the information is **written legibly.** (If you hav prescriptions, please add additional sheets)

**Check one**

| **Drug Name**<br>**Please write the name of the drug as well as the name of the generic if applicable.** | **Name Brand** | **Generic** | **Dosage** | **Frequency per Day** | **Monthly quantity of pills, vials, packages, inhaler, etc.** |
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**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**