Pre-Enrollment Form

MEDICARE OPEN ENROLLMENT October 15th to December 7th

Return Completed Form To: sherri.bush@atrc.net or Fax to 334-682-4045

Exact Name on Medicare Card	Date of Birth	Birth Place (city, state, country)

Spouse/Former Spouse Name: Spouse/Former Spouse Date of Birth:

Your Social Security #: Spouse/Former Spouse SS #:

Are You a Veteran? ☐Yes ☐No Spouse/Former Spouse a Veteran? ☐Yes ☐No

Physical Address: Email: County:

Mailing Address: Phone: ( ) or ( )

Number of other dependents: Marital Status: Reside with a spouse? ☐Yes ☐No

Other contact name/phone: I last contacted SHIP in _____ (year)

Currently enrolled in: Original Medicare☐ or Name of Managed Care Plan _____

Name of any Medicare Supplement _____ Plan Letter ____ Monthly premium _____

Name of other current health insurance: _____ ☐Retiree plan ☐Active employee plan

☐Veterans Administration ☐Federal retiree ☐State or public education retiree ☐TRICARE for Life

Medicare Card Information

Medicare Card Number:
SEE EXAMPLE ON THE BACK

Part A effective Date:

Part B effective Date:

Zip code where I receive Social Security mail:

Do you need a new Medicare Card? ☐Yes ☐No

MyMedicare.gov Account Info

☐ I set up my own MyMedicare.gov Account

User ID: Password:

Security Question/Answer:

Zip code of any representative payee:

Do you prefer not to provide this information?

Income/Subsidy Information/POA

My own gross monthly income: $_____

Spouse gross monthly income: $_____

Is any of this income wages, salary, or self-employment? ☐Yes ☐No

Are you currently receiving? ☐Extra Help/LIS

☐SSI ☐Medicaid Waiver ☐QMB ☐SLMB/QI

Pharmacy Information

Do you have a power of attorney? ☐Yes ☐No

Preferred Pharmacy?_____

Alternate Pharmacy?_____

Do you use Mail Order? ☐Yes ☐No

Prescriptions not covered by current plan: ☐ None

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLE TO	EFFECTIVE DATE
HOSPITAL (PART A)	
MEDICAL (PART B)	

Please list each of your prescriptions in the two columns below.

For each, list the **name exactly as it appears on the container**, **the strength,** mg, mcg, ml, or other strength, **the form**, such as TAB, CAP, cream, ointment, liquid, etc., and **the amount of each fill**, such as 30/mo, 90/3 mo, 1 tube/mo, 2 vials/3 mo, 1 bottle/3 mo, 5 boxes of 3 pens/3 mo, etc.
Remember to include injections, breathing treatments, ointments, creams, etc.

Prescriptions	Prescriptions

Contact Preferences:

FOR OFFICE USE ONLY:

Contact Date and Time:_____ **Counselor Name:** _____

Sent Comps, Materials, Mail ☐ **Emailed** ☐ **Fax Date**_____