Aging and Disability Resource Center of Door County

Medicare Open Enrollment Packet

Medicare Annual Open Enrollment Period: October 15-December 7

How Do I Compare My Plan Options?

Option 1: Do-It-Yourself

Once you have completed the Medicare Plan Finder Information, you can use it to find and enroll in a Medicare drug plan that meets your needs:

Online by using www.Medicare.gov to compare options.

How-to guide on using Medicare.gov: https://youtu.be/Va7JtuxEyLc?si=np7T08tJiUtn8MTZ (video)

Assistance is also available through:

- The Medigap Helpline 1-800-242-1060. Free and unbiased advice (all complete by phone)
- Medigap Part D and Prescription Drug Helpline 1-855-677-2783, for WI residents 60+
- A local trusted Health Insurance Agent
- Medicare/CMS: 1-800-633-4227 to have Medicare staff review plan options by phone 24/7

Option 2: Local assistance through the ADRC:

Complete and return both enclosed forms no later than November 25th, 2026:

By Mail or Drop off:	By Fax:
ADRC of Door County Attn: SHIP 914 N 14th Avenue Sturgeon Bay, WI 54235	920-746-7150

Once your forms are received, a Benefit Specialist/SHIP Counselor will:

1. Review your forms for completeness. We will contact you and may request you come to fill in missing information-so please complete in full to avoid delays;
2. We can mail, email, or have ready for pick-up plan options and results; **or**
3. Contact you to schedule an appointment time to review your options. The Benefit Specialist and SHIP Program Counselors will provide free, unbiased information about your plan options. We are unable to give recommendations as to what plan you should choose but can help you understand plan information and options

Medicare Part D or Medicare Advantage Plan Comparison Request

I am requesting assistance from the Elder Benefit Specialist, Disability Benefit Program, and SHIP Volunteer Counselors in gathering Medicare Advantage or Part D plan options. I understand:

* Enrollment into an Advantage Plan or Part D Plan can only be done during a person's Medicare initial enrollment period; Medicare's annual open enrollment period; Medicare's Advantage open enrollment; or during one of Medicare's special enrollment periods.
* The Medicare.gov Plan Finder provides **estimates** ONLY. I understand I am strongly advised to call a plan directly to confirm that the information I am relying on from the Plan Finder is accurate.
* This form is only a screening tool and NOT an actual application for a plan.
* I am responsible for my own enrollment. Although the Benefit Specialist can assist me with enrolling, it is my responsibility to assure that I have been enrolled. Elder/Disability Benefit Specialist or SHIP Volunteer enrollment assistance into a plan is not a recommendation as to which plan is best for me.

Comparison You Are Requesting:

❒ **Prescription Only Plan (PDP)-Original Medicare**

❒ **Medicare Advantage Plan WITH drug coverage**

❒ **Advantage Plan WITHOUT drug coverage (usually for those with other prescription coverage-such as VA or private plans)**

I Would Like My Results:

❒ **I would like my plan comparison sent to me by mail and I will enroll myself**

❒ **Reviewed with a Benefit Specialist/SHIP Counselor. (ADRC staff will call you to set up an appointment)**

Please PRINT information as clearly as possible.

Name:		Birthdate:	
Street Address:		Age:	☐ Male ☐ Female
City:	State:	Zip Code:	

Mailing Address (if different than residence):

Phone #:	Email:
Medicare ID (number from your red/white/blue Medicare card):	Medicare Part A Effective Date: Medicare Part B: Effective Date:
Current PDP or Advantage Plan (write name from your insurance card or attach a copy)	Plan name:

Are you also enrolled in any of the following other HealthCare Programs? (check all that apply)

☐ Veterans Administration (VA)	☐ Wisconsin State Medicaid or Medicare Savings Program (QMB, SLMB or SLMB+)	☐ Wisconsin SeniorCare
☐ TRICARE for Life (Military)		☐ Employee Group or retiree plan
☐ Medications through the VA		☐ Union Coverage

Preferred Pharmacy (Can compare up to five different pharmacies. If you want to compare more than 2, please use extra paper)

#1:	Location/City:
#2:	Location/City:

☐ I get my prescriptions by mail-order. ☐ I might get prescriptions by mail-order, if cheaper.

Medication List

- **PLEASE READ THOUROUGHLY** **List below current prescriptions that you need your prescription plan to cover**. You could instead attach a printout from your pharmacy- review it for accuracy first and ensure it lists all the same information as requested below. Cross out over-the-counter meds, meds you no longer take and meds that don't need to be covered in your plan (such as meds you get for free through a patient financial assistance program). **DO NOT PUT IN "AS NEEDED"** Use best estimate for "as needed" meds (even if 1 pill 1x/year). Medicare.gov **requires** this information and you will not get a good estimate if you are missing details. If you have more than 40 prescriptions, you will need to contact 1-800-Medicare for assistance.

Current Prescription Name	Dosage and Type	Quantity	Refilled how often?
Look at the prescription container closely and include the entire name	i.e. mg, mcg, ml, etc. i.e. Tablet, capsule, vial, tub, jar, pen, ointment, syringe, etc.	How many do you order at a time?	Monthly? Every 2 months? Every 3 mo ? Etc.
Example: Trulicity	**1.5ml/.5ml pens**	**3 boxes of 4**	**Every 2 months**
Example: Glipizide/Metformin	**2.5- 250mg tablets**	**60**	**Monthly**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Primary Provider Name/Office Location: _____

I have read and agree with the information provided to me on this form.

_____ _____
Client signature Date

_____
Client name – printed

Please double check for completeness. Incomplete forms or missing information will delay appointments or give you incomplete results.