PETER A. TORIGIAN SENIOR CENTER

Peabody Council on Aging
75R Central Street, Peabody, MA 01960
Phone: (978) 531-2254/Fax: (978) 531-7176
www.peabodycoa.org

Mail or fax back attention SHINE
The Annual Medicare Part D Open Enrollment is **October 15-December 7**
Every year plans change. We can help you determine the best plan option available for you.

(Please fill out this information according to how it appears on your Medicare health Insurance Card)

First Name_____Middle_____Last_____Suffix_____

Address_____City_____State_____Zip_____

Day-time Phone Number_____ Alternate Phone Number _____

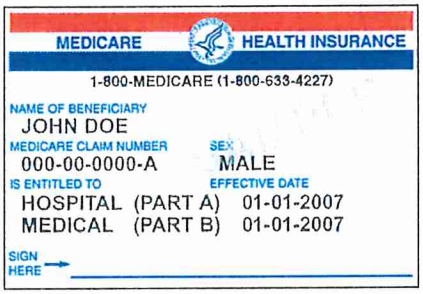
Date of Birth _____ Medicare Claim Number _____

Effective Date Part A _____ Effective Date Part B _____

What prescription drug plan do you currently have? _____

Are you satisfied with your current plan? Yes _____ No _____

What is the name of your pharmacy? _____


MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JOHN DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
MALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A) 01-01-2007
MEDICAL (PART B) 01-01-2007
SIGN HERE

Please answer the following to determine if you are eligible for assistance

Do you have MassHealth? _____ Do you have Prescription Advantage? _____

How many people in your household? _____ What is your monthly household income? _____

Amount of assets (savings accounts, stocks, etc)? _____

List of medications (if you have more medications or questions, please use the back of this form)

Name	Dosage	Frequency

Name	Dosage	Frequency

Questions: _____

Authorization Form for the Release of Information

The Serving Health Insurance Needs of Everyone (SHINE) Program is a health benefits information, counseling and assistance program administered by the Executive Office of Elder Affairs. It provides confidential counseling on health insurance options for Medicare beneficiaries of all ages and their caregivers.

I authorize _____(SHINE Counselor)

of Peabody Council on Aging *(SHINE site)*, to ask about and receive protected health information on the following: *(One or more may apply)*

- ☑ Medicare Information to create a MyMedicare.gov account:_____
- ☐ Eligibility information: _____
- ☐ Health insurance coverage issued by: _____
  My Policy/ Member ID Number: _____

- ☐ Other matters described here:

  _____

  _____.

This authorization allows the SHINE counselor to receive my protected health information for the purpose of establishing a MyMedicare Account which will facilitate a Medicare Plan finder search.

This authorization will be valid for one day: Date_____

Please retain this Authorization Form for Release of Information in your files for future inquiries from the person named above.

- I understand I may cancel this authorization at any time.

_____
Signature of Consumer

_____
Authorized Representative (if applicable)

_____
Print Name

_____
Address

_____
Phone Number

_____*Date*