2026 Open Enrollment Drug Screening Form

It is the responsibility of the Medicare Beneficiary or their legal representative to enroll into a plan; however, CHOICES will help facilitate the enrollment through www.medicare.gov portal. The results from this screening can assist the beneficiary in making an informed personal decision when enrolling into a Medicare Part D plan or a Medicare Advantage Plan. This form is not an enrollment form into a Medicare Part D plan or a Medicare Advantage Plan.

Instructions: Complete both sides of this form and return to _____.

Name:	**DOB:**
Street Address:	
ZIP:	
Phone Number:	
Email Address:	

Current prescription drug plan (PDP): _____ None yet: ☐

Please check all that apply:

- ☐ You are NEW to Medicare, as of when? Part A: _____ Part B: _____
- ☐ You have Medicaid/Husky
- ☐ The State pays your Part B Premium (You have The Medicare Savings Program)
- ☐ You have Veteran Benefits
- ☐ You will no longer have creditable employer or retirement prescription insurance
- ☐ Other: _____.

This program is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of 2 financial assistance awards totaling $925,388 with 100 percent funding by ACL/HHS. Approximately 60% SHIP, 40% MIPPA. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. Government.

Please provide us with information about your prescriptions and pharmacy choice. You may be able to obtain a computerized listing from your pharmacy – please feel free to attach; otherwise, it is best to take the information directly from your prescription label.

Pharmacy of choices, you may list up to three:

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

Name of Drug	Dosage/Strength	Quantity	Refill supply 30 day or 90 day?
Example: Simvastatin	*30 mg*	*1 x per day*	*90-day supply*

Return completed form to:

OFFICE USE ONLY:

Date Plan comparison sent to client:

Mail: _____

Or

Email:

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