Date: _____ **Referral to SHIBA from APD**

Name: _____

Please call SHIBA at _____(site),

_____(phone number) for an appointment to help you with the following:

Medicare

___ Explain eligibility, enrollment, benefits
___ Claims/appeals

Medicare Supplement Ins.

___ Explain
___ Change, suspend, drop coverage

Medicare Drug Coverage

___ Compare plans
___ Enroll/Disenroll
___ Claims
___ Exception/appeal

Medicare Advantage

___ Explain plan
___ Enroll/Disenroll
___ Claims
___ Appeals

Financial Assistance with Rxs

___ LIS Application
___ Patient Assistance Programs

Other (Explain)

_____

_____

DHS information which may be needed:

Program Enrollment	**Effective Date**
_____	_____
_____	_____

(Indicate if individual has applied for a program but eligibility has not yet been determined.)

Medicare Part D Information:

If auto-enrolled in a Part D Plan—
Name of Plan_____
Effective Date_____

APD Contact Name _____
APD Contact Phone _____ Email _____

Date: _____ **Referral from SHIBA to APD**

Name: _____

Please call _____(site),

_____(phone number) for an appointment to help you with the following:

Medicare Premium Assistance

___ Part A

___ Part B

___ Both Part A&B

Services

___ Services eligibility determination

Other (Explain)

_____

_____

Information that APD might find useful:

_____

_____

(Indicate if individual has applied for a program but eligibility has not yet been determined.)

Other Medicare Information:

If enrolled in a Part D Plan—

Name of Plan _____ Effective Date _____

If enrolled in a Medicare Advantage Plan—

Name of Plan _____ Effective Date _____

If enrolled in a Medicare Supplement (Medigap) Plan—

Name of Plan _____ Effective Date _____

If applied for / enrolled in a Limited Income Subsidy (LIS)—

Application Date _____ Effective Date _____

SHIBA Counselor _____

Counselor phone _____ Email _____