Date: _____

Referral to SHIBA

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 _____