

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 Rx's

- ___ 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

Services

___ Part A

___ Services eligibility determination

___ Part B

___ Both Part A&B

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 _____