# Medicare Counseling over the Phone and by Email: Information to Provide

Please complete all information fields and return to:
Berks Encore
ATTN: APPRISE Department
40 N. 9th Street
Reading, PA 19601

Below are questions you need to answer in order for us to re-evaluate your Medicare Part D Plan or Medicare Advantage Plan. Please provide as much information as possible. That way, we can find the best possible options for your personal situation. Please use a separate form for each person requesting counseling.

Name _____ Date: _____

Email: _____

Please circle your answer:

Would you like an appointment by Email? YES NO
(If you choose an Email appointment, we will Email your lowest cost options to you)

Would you like an appointment over the phone? YES NO

When is the best day of the week to call you? (You can choose more than one day)

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

When is the best time to call you? 8:30-12:00 OR 12:00-3:30 OR Anytime

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Other Information to provide:

- Are you enrolled in the state MEDICAID program? YES NO
- Are you enrolled in the Extra Help program through Social Security? YES NO
- Are you a member of the PACE/PACENET program? YES NO

*If you have any questions prior to your appointment, please call Berks Encore at (610) 374-3195 x208 OR email us at Apprise@BerksEncore.org*

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**MEDICATIONS (Please use a separate sheet for each person)**
Please list below all of the medications you use, or attach a list. If you are having trouble filling out this form, ask your pharmacist to print a list.

| **Current Medications (generic & brand name)** | **Strength** | **Daily Dosage** |
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The Pharmacy I use: _____
I use mail order: YES NO
My Current Coverage: _____

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|---|---|
| **Name(as shown on Medicare ID):** | |
| **Address Lines 1 & 2:** | |
| **City, State, Zipcode:** | |
| **My phone number:** | |
| **Medicare ID:** | **Part A effective date:** **Part B effective date:** |
| **Date of Birth:** | |