GOLDEN TRIANGLE PLANNIG AND DEVELOPMENT DISTRICT
106 Miley Drive/P.O. Box 828 (39760)
Starkville, MS 39759

Open Enrollment for Prescription Drug Coverage
Oct. 15 – Dec. 7
Part D Medicare 2025

ALL APPOINTMENTS WILL BE BY PHONE

Appointment Time /Date_____

Thank you for contacting GTPDD SHIP Program for assistance with your Medicare Part D Open Enrollment coverage evaluation.

We are not seeing any beneficiaries in the office. **All appointments must be via phone.**

Complete the attached form and return it to the office as soon as possible. We do a lot of preparation before open enrollment begins so we need your information **AS SOON AS POSSIBLE**. All appointments will be held via phone. Complete the requested personal information form and return to the office. You will receive a phone call on the assigned date. We will call as close to the assigned time as possible but sometimes our schedule varies based on a client's needs. Please be flexible. If we have not called by the end of the day please call us!

All beneficiaries MUST have a MyMedicare account. If you do not have an account, we will set up one for you. If we set up your account you will receive a letter from CMS stating that the account has been set up. **Do not Cancel this account. If you cancel this account, we will NOT be able to assist you.**

The attached form must be complete. If any of the information is missing, we will not be able to serve you.

- Name – as it appears on your Medicare Card – PLEASE PRINT CLEARLY
- Address – current mailing address including zip code
- Date of Birth – Month/Day/Year
- Social Security Number
- Medicare Number or a copy of your NEW Medicare Card
- **NEW LIST OF CURRENT MEDICATIONS** – Attached is a form for your use. Please complete the form and return it to the above address.
- **DO NOT** send a list printed from your pharmacy or doctor's office. These lists are for all medications taken during the entire year, as well as over-the-counter medications that are not covered by Medicare Part D. Send only a list of **CURRENT** medications that you want to be considered when looking for a 2025 drug plan.

KEEP THIS SHEET FOR YOUR RECORDS AS A REMINDER OF YOUR APPOINTMENT TIME AND DATE

Be sure to answer your phone!

THIS FORM MUST BE COMPLETED AND RETURNED ASAP!
2025 Medicare Part D ASSISTANCE FORM

All Appointments are by PHONE!!!!

Appointment Date and Time _____

Name _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Medicare Number _____ Part A Effective date _____

Complete Social Security Number _____

List only prescription drugs that you are currently taking or drugs you want to be considered when looking for a 2025 drug plan. **Do not list over-the-counter medications – DO NOT SEND PRINTED MEDICATION LISTS FROM THE PHARMACY OR DOCTOR– LIST ONLY MEDS YOU WANT CONSIDERED ON YOUR COMPARISON!!! DO NOT INCLUDE DIAGNOSIS OR WHY YOU TAKE A MEDICATION. USE THE BACK OF THE FORM IF YOU NEED MORE SPACE.**

Example:

Medication Name	Mg.	Qty of Pills per month
Lisinopril	5mg.	30

Medication Name	**Mg.**	**Qty pills per month**

Your Pharmacy Choice _____

If you have a myMedicare account please provide the following information:

User Name _____

Password: _____