

BENEFICIARY CONTACT FORM

*** Items marked with asterisk (*) indicate required fields**

MIPPA Contact *: ☐ Yes ☐ No

Send to SMP: ☐ Yes ☐ No **SIRS eFile ID:**
(*required if sending record to SMP)

Counselor Information *

Session Conducted By * : _____ ZIP Code of Session Location * : _____ State of Session Location * : _____
Partner Organization Affiliation * : _____ County of Session Location * : _____

Beneficiary & Representative Name and Contact Information

Beneficiary First Name: _____ Representative First Name: _____
Beneficiary Last Name: _____ Representative Last Name: _____
Beneficiary Phone: (_____) - _____ - _____ Representative Phone: (_____) - _____ - _____
Beneficiary Email: _____ Representative Email: _____

Beneficiary Residence *

State of Bene Res. * : _____ Zip Code of Bene Res. * : _____ County of Bene Res. * : _____

Date of Contact * :

How Did Beneficiary Learn About SHIP * (select only one):

☐ CMS Outreach ☐ Previous Contact ☐ SHIP TA Center ☐ Other
☐ Congressional Office ☐ SHIP Mailings ☐ SSA ☐ Not Collected
☐ Friend or Relative ☐ SHIP Media ☐ State Medicaid Agency
☐ Health/Drug Plan ☐ SHIP Presentation ☐ 1-800 Medicare
☐ Partner Agency ☐ State SHIP Website

Method of Contact * (select only one):

☐ Phone Call ☐ Face to Face at ☐ Face to Face at
☐ Email Session Location/ Bene Home/
☐ Web-based Event Site Facility
☐ Postal Mail or Fax

Beneficiary Age Group * (select only one):

☐ 64 or Younger ☐ 85 or Older
☐ 65 – 74 ☐ Not Collected
☐ 75 – 84

Beneficiary Gender * (select only one):

☐ Female
☐ Male
☐ Other
☐ Not Collected

Beneficiary Race * (multiple selections allowed):

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Not Collected
☐ Hispanic or Latino

Beneficiary Language *:

English is Beneficiary's Primary Language ☐ Yes ☐ No

Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):

☐ Yes ☐ No

Beneficiary Monthly Income * (select only one):

☐ Below 150% FPL ☐ Not Collected
☐ At or Above 150% FPL

Beneficiary Assets * (select only one):

☐ Below LIS Asset Limits ☐ Not Collected
☐ Above LIS Asset Limits

Topics Discussed * (At least one Topic Discussed selection is required. Multiple selections allowed)

Original Medicare (Parts A & B)
☐ Appeals/Grievances
☐ Benefit Explanation
☐ Claims/Billing
☐ Coordination of Benefits
☐ Eligibility
☐ Enrollment/Disenrollment
☐ Fraud and Abuse
☐ QIO/Quality of Care

Medigap and Medicare Select
☐ Benefit Explanation
☐ Claims/Billing
☐ Eligibility/Screening
☐ Fraud and Abuse
☐ Marketing/Sales Complaints & Issues
☐ Plan Non-Renewal
☐ Plans Comparison

Topics Discussed (multiple selections allowed) (continued from p.1)***Medicare Advantage (MA and MA-PD)**

- ☐ Appeals/Grievances
- ☐ Benefit Explanation
- ☐ Claims/Billing
- ☐ Disenrollment
- ☐ Eligibility/Screening
- ☐ Enrollment
- ☐ Fraud and Abuse
- ☐ Marketing/Sales Complaints & Issues
- ☐ Plan Non-Renewal
- ☐ Plans Comparison
- ☐ QIO/Quality of Care

Medicare Part D

- ☐ Appeals/Grievances
- ☐ Benefit Explanation
- ☐ Claims/Billing
- ☐ Disenrollment
- ☐ Eligibility/Screening
- ☐ Enrollment
- ☐ Fraud and Abuse
- ☐ Marketing/Sales Complaints & Issues
- ☐ Plan Non-Renewal
- ☐ Plans Comparison

Part D Low Income Subsidy (LIS/Extra Help)

- ☐ Appeals/Grievances
- ☐ Application Assistance
- ☐ Application Submission
- ☐ Benefit Explanation
- ☐ Claims/Billing
- ☐ Eligibility/Screening
- ☐ LI NET/BAE

Other Prescription Assistance

- ☐ Manufacturer Programs
- ☐ Military Drug Benefits
- ☐ State Pharmaceutical Assistance Programs
- ☐ Union/Employer Plan
- ☐ Other

Medicaid

- ☐ Application Submission
- ☐ Benefit Explanation
- ☐ Claims/Billing
- ☐ Eligibility/Screening
- ☐ Fraud and Abuse
- ☐ Medicaid Application Assistance
- ☐ Medicare Buy-in Coordination
- ☐ Medicaid Managed Care
- ☐ MSP Application Assistance
- ☐ Recertification
- ☐ Other

Other Insurance

- ☐ Active Employer Health Benefits
- ☐ COBRA
- ☐ Indian Health Services
- ☐ Long Term Care (LTC) Insurance
- ☐ LTC Partnership
- ☐ Other Health Insurance
- ☐ Retiree Employer Health Benefits
- ☐ Tricare For Life Health Benefits
- ☐ Tricare Health Benefits
- ☐ VA/Veterans Health Benefits
- ☐ Other

Additional Topic Details

- ☐ Ambulance
- ☐ Dental/Vision/Hearing
- ☐ DMEPOS
- ☐ Duals Demonstration
- ☐ Home Health Care
- ☐ Hospice
- ☐ Hospital
- ☐ New Medicare Card
- ☐ New to Medicare
- ☐ Preventive Benefits
- ☐ Skilled Nursing Facility

Total Time Spent on This Contact *

____ Hours ____ Minutes

Status *☐ In Progress ☐ Completed**Special Use Fields**

Original PDP/MA-PD Cost: _____

Field 3: _____

New PDP/MA-PD Cost: _____

Field 4: _____

Field 5: _____

Notes