

Mystic Valley SHINE - Part D Review Form

The purpose of this form is to have a SHINE counselor review your current stand-alone Part D coverage and make recommendations for 2027. If you have more drugs than can be listed on this page please attach additional pages, or attach a drug list from your pharmacy. Email this form to SHINE@mves.org, or mail to SHINE at 300 Commercial St. Malden, MA 02148.

Name:

Date of Birth:**Address:****Phone:**

Email Address:

➡ Current Plan (Insurer and Name):

Premium: \$

Please send results by: ☐ Email ☒ Mail

Medicare Card Information		Medicare.gov Account Info	
Name:		User Name:	
Number:		Password:	
Part A effective Date:		Security Question:	
Part B effective Date:		Answer:	
Income/Subsidy Information		Pharmacy Information	
Does your monthly income fall below \$2,993 for Single or \$4,058 for Married couple? ☐ Yes ☐ No		Preferred Pharmacy?	
		Alternative Pharmacy?	
Do you have a Medicare Savings Program (MSP) or MassHealth? ☐ Yes ☒ No		Do you use Mail Order? ☐ Yes ☐ No	

Prescription Drugs – Specify if brand name is mandated, otherwise generics will be used[illegible]