# BENEFICIARY CONTACT FORM

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

Date of Contact *:

| | | | |
|---|---|---|---|
| **MIPPA Contact *:** | ❑ Yes ❑ No | | |
| **Send to SMP:** | ❑ Yes ❑ No | **SIRS eFile ID: (*required if sending record to SMP)** | |

**Counselor Information ***

Session Conducted By* : _____

Partner Organization Affiliation* : _____

ZIP Code of Session Location * : _____

State of Session Location * : _____

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. * : _____

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

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

**Method of Contact * (select only one):**

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

**Beneficiary Age Group * (select only one):**

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

**Beneficiary Gender * (select only one):**

❑ Female
❑ Male
❑ Other
❑ Not Collected

**Beneficiary Race * (multiple selections allowed):**

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

**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

**Have you or a family member ever served in the military?**

❑ Yes ❑ No ❑ Unsure

**Beneficiary Monthly Income * (select only one):**

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

**Beneficiary Assets * (select only one):**

❑ Below LIS Asset Limits
❑ Above LIS Asset Limits
❑ Not Collected

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

**Original Medicare (Parts A & B)**
- ❑ Accountable Care Organizations (ACOs)
- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Conditional Enrollment
- ❑ Coordination of Benefits
- ❑ Eligibility
- ❑ Enrollment/Disenrollment
- ❑ Equitable Relief
- ❑ Fraud and Abuse
- ❑ Late Enrollment Penalty
- ❑ Provider Participation
- ❑ QIO/Quality of Care

**Medigap and Medicare Select**
- ❑ Application Assistance
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Complaints
- ❑ Eligibility/Screening
- ❑ Fraud and Abuse
- ❑ Guaranteed Issue Rights
- ❑ Plan Non-Renewal
- ❑ Plans Comparison

**Medicare Advantage (MA and MA-PD)**
- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Chronic Condition Special Needs Plans
- ❑ Claims/Billing
- ❑ Disenrollment
- ❑ Dual Eligible Special Needs Plans
- ❑ Eligibility/Screening
- ❑ Enrollment
- ❑ Fraud and Abuse
- ❑ Institutional Special Needs Plans
- ❑ Marketing/Sales Complaints & Issues
- ❑ Plan Non-Renewal
- ❑ Plans Comparison
- ❑ Provider Network
- ❑ QIO/Quality of Care
- ❑ Supplemental Benefits

  Please explain:

  _____

**Medicare Part D**
- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Disenrollment
- ❑ Eligibility/Screening
- ❑ Enrollment
- ❑ Fraud and Abuse
- ❑ Late Enrollment Penalty
- ❑ Marketing/Sales Complaints & Issues
- ❑ Pharmacy Network
- ❑ 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
- ❑ Prescription Discount Cards
- ❑ State Pharmaceutical Assistance Programs
- ❑ Union/Employer Plan

**Medicaid**
- ❑ Appeals/Grievances
- ❑ Benefit Explanation
- ❑ Claims/Billing
- ❑ Duals Demonstration
- ❑ Eligibility/Screening
- ❑ Fraud and Abuse
- ❑ Medicaid Application Assistance
- ❑ Medicaid Application Submission
- ❑ Medicare Buy-In Coordination
- ❑ Medicaid Expansion (ACA) Transition to Medicare
- ❑ Medicaid Recertification
- ❑ Medicare Buy-in Coordination
- ❑ Medicaid Managed Care
- ❑ Medicaid Spend Down
- ❑ MSP Application Assistance
- ❑ MSP Application Submission
- ❑ MSP Recertification
- ❑ Program of All-Inclusive Care for the Elderly (PACE)
- ❑ Provider Participation
- ❑ QMB Improper Billing

**Other Insurance**
- ❑ Active Employer Health Benefits
- ❑ COBRA
- ❑ Indian Health Services
- ❑ Long Term Care (LTC) Insurance
- ❑ LTC Partnership
- ❑ Marketplace Transition to Medicare
- ❑ Other Health Insurance
- ❑ Retiree Employer Health Benefits
- ❑ Tricare For Life Health Benefits
- ❑ Tricare Health Benefits
- ❑ VA/Veterans Health Benefits

**Topics Discussed (multiple selections allowed) (continued from p. 2)***

**Additional Topic Details**

- ❑ Ambulance
- ❑ COVID-19
- ❑ Dental/Vision/Hearing
- ❑ DMEPOS
- ❑ ESRD
- ❑ Health Savings Account(s)
- ❑ Home Health Care
- ❑ Hospice
- ❑ Hospital
- ❑ Income Related Monthly Adjustment Amount
- ❑ Mail Order Prescription
- ❑ Medicare Card
- ❑ Mental Health
- ❑ Medicare.gov Account
- ❑ New to Medicare
- ❑ Opioids
- ❑ Physical Therapy
- ❑ Preventive Benefits
- ❑ Skilled Nursing Facility
- ❑ Substance Misuse/Fraud/Abuse
- ❑ Telehealth
- ❑ Transportation

| **Total Time Spent on This Contact *** | **Status *** |
|---|---|
| ____ Hours _____ Minutes | ❑ In Progress ❑ Completed |

**Special Use Fields**

Original PDP/MA-PD Cost: _____

New PDP/MA-PD Cost: _____

Field 3: _____

Field 4: _____

Field 5: _____

**Notes**