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)**	This field will automatically utilize the SIRS eFile ID entered on the Session Conducted By user's SHIP Team Member form

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 Beneficiary Home/ Facility

Beneficiary Age Group * (select only one):

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

Which of the following best represents how you think of yourself? (Multiple selections allowed):

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ Don't know
- ❑ Prefer not to answer
- ❑ I use a different term
  Other Orientation Term: _____

What is your current gender? (select only one):

- ❑ Female
- ❑ Male
- ❑ Transgender
- ❑ Don't know
- ❑ Prefer not to answer
- ❑ I use a different term
  Other Orientation Term: _____

Do you consider yourself to be transgender? (Select only one): ❑ Yes ❑ No ❑ Prefer not to answer

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

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

❑ Yes ❑ No ❑ Unsure

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)

❑ 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:
_____

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
❑ 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)*

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

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
- ❑ Medicare.gov Account
- ❑ Mental Health
- ❑ New to Medicare
- ❑ Opioids
- ❑ Physical Therapy
- ❑ Preventive Benefits
- ❑ Skilled Nursing Facility
- ❑ Substance Misuse/Fraud/Abuse
- ❑ Telehealth
- ❑ Transportation

Total Time Spent on This Contact *

____ Hours _____ Minutes

Status

❑ In Progress ❑ Completed

Special Use Fields

Original PDP/MA-PD Cost: _____

New PDP/MA-PD Cost: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes