|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Beneficiary Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Beneficiary Phone: ( \_\_\_\_\_\_ ) -\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_\_  Beneficiary Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Representative First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Representative Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Representative Phone: ( \_\_\_\_\_\_ ) -\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_\_  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):** | | | | | | | | | | | | | | | | **Beneficiary Age Group \***  **(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 | | | | | | | | | | | | | * 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):** | | | | | | | | | | | **What is your current gender?**  **(select only one):** | | | | | | | | | | | | | | | |
| * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | * 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):** | | | | | | | | | | | **Beneficiary Language \*:** | | | | | | | | | | | | | | | |
| * American Indian or Alaska Native * Asian * Black or African American * Hispanic or Latino | | | | | | * Native Hawaiian or Other Pacific Islander * White * Not Collected | | | | | 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):** | | | | | | | | | | | **Beneficiary Assets \* (select only one):** | | | | | | | | | | | | | | | |
| * Below 150% FPL * At or Above 150% FPL | | | | * Not Collected | | | | | | | * 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)**  **Medigap and Medicare Select**  **Medicare Advantage (MA and MA-PD)** | * 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 * Application Assistance * Benefit Explanation * Claims/Billing * Complaints * Eligibility/Screening * Fraud and Abuse * Guaranteed Issue Rights * Plan Non-Renewal * Plans Comparison * 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)**  **Other Prescription Assistance**  **Medicaid**  **Other Insurance** | | | | | | * Appeals/Grievances * Application Assistance * Application Submission * Benefit Explanation * Claims/Billing * Eligibility/Screening * LI NET/BAE * Manufacturer Programs * Military Drug Benefits * Prescription Discount Cards * State Pharmaceutical Assistance Programs * Union/Employer Plan * 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 * 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 \*** | | | | | | | | | | | | **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** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |