|  |
| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 Bene Home/ Facility
 | * 64 or Younger
* 65 – 74
* 75 – 84
 | * 85 or Older
* Not Collected
 |
| **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
 |
| **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):** | **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
 |

|  |
| --- |
| **Sexual Orientation** **\*** |
| Which of the following best represents how you think of yourself? [Select ONE]: * Lesbian or gay
* Straight, that is, not gay or lesbian
* Bisexual
* I use a different term \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Don’t know
* Prefer not to answer
 |
| **Gender Identity** **\*** |
| What is your current gender [Select ONE]* Female
* Male
* Transgender
* I use a different term: [free text]
* Don’t know
* Prefer not to answer

Do you consider yourself to be transgender?* Yes
* No
* Prefer not to answer
 |
| **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)** **Medicare Part D**  | * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * 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)** **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
* 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
* 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** |
|  |