Division of Aging and Adult Services
Department of Community and Human Services
4850 Mark Center Drive. 9th Floor
Alexandria, VA 22311
703-746-5999

October 8, 2023

Dear Medicare Recipient,

Medicare Open Enrollment, **October 15- December 7, 2023**, is the period when you can make changes to your Medicare prescription drug plan also known as **Medicare Part D**.

Everyone with a Medicare Part D prescription drug plan and Medicare Advantage plan with drug coverage should review their coverage to check for the following:

- Changes in the monthly cost you pay for your plan (the premium).
- The cost of each medication you take, as costs may increase or decrease.
- Ensure all your prescription drugs are covered by your current Part D prescription drug plan.

You should have received your Annual Notice of Change from your insurance company. This tells you about changes in coverage, costs, or service area that will be effective on January 1, 2024.

The Alexandria City VICAP office can help you to review your Medicare Part D prescription plan and ensure it meets your needs. If you would like help, please complete the enclosed information form and return it to our offices and a counselor will work with you to determine the best plan for you.

You can also visit our website at www.alexandriava.gov/aging to submit this form electronically and for a step-by-step instructions on how to check your benefits or visit Medicare.gov website to compare plans using the Medicare Plan Finder.

Please disregard this letter if you do not have Medicare or do not want to review or change your Medicare Part D Plan.

If you have further questions, please leave a message at 703-746-5712 or email VICAP@alexandriava.gov.

Sincerely,

VICAP Coordinator

For Medicare Part D (Prescription Plan) or Part C (Medicare Advantage Plans)

The ANNUAL ENROLLMENT PERIOD for PART D is October 15 to December 7 each year.

Changes made during this period will be effective JANUARY 1, 2024.
For assistance reviewing, changing or enrolling in a plan, please return this form by email, mail, or complete this form online, by visiting our website:

www.alexandriava.gov/aging

Email: VICAP@alexandriava.gov

*****ONLY COMPLETE IF YOU ARE A MEDICARE BENEFICIARY*****

Seeking assistance with:
☐ **Prescription plan (Part D)**
OR
☐ **Medicare Advantage plan (Part C)**

In order to provide a personalized Medicare search for prescription drug plans, you must have a Medicare Account. In order for Alexandria City VICAP counselors to provide a drug coverage analysis, you must choose **ONE** of these following options.

Check one of the following:

☐ I do not have a Medicare Account, but I want a personalized search. I give permission for the Alexandria City VICAP Counselors to create a My Medicare Account. Counselors will send me the account username and password with my analysis.

(Name) _____(Signature) _____Date_____

☐ I have a Medicare Account and I want a personalized search. I authorize VICAP counselor to access my account information:

Username: _____
Password: _____

(Name) _____(Signature) _____Date_____

Finally, I agree to counseling under provisions and guidelines of the Virginia State Health Insurance and Assistance Program (VICAP). I understand that counselors will use the information that I provide to assist me with my Medicare coverage options and will keep my personal information confidential.

(Name) _____(Signature) _____Date_____

For Medicare Part D (Prescription Plan) or Part C (Medicare Advantage Plans)

The ANNUAL ENROLLMENT PERIOD for PART D is October 15 to December 7 each year.

Changes made during this period will be effective JANUARY 1 of the following year.
For assistance to review and change a plan or enroll in a plan, please return this form.
Complete this form online, please visit our website: www.alexandriava.gov/aging
Email: VICAP@alexandriava.gov

Mail to: Alexandria DCHS- Aging and Adult Services Division
Attn: VICAP
4850 Mark Center Dr. 9th Floor
Alexandria, VA 22311
Or EMAIL to VICAP@alexandriava.gov

*****ONLY COMPLETE IF YOU ARE A MEDICARE BENEFICIARY*****

NAME as it appears on your Medicare Card: **(Mr./Ms.)** _____

Address: _____Zip Code: _____

Phone #: _____ Date of Birth: _____

Email: _____

Race: ☐ White ☐ Black/African American ☐ Indian ☐ Asian ☐ Alaskan Native ☐ Other

Person to Contact, If Other Than You: _____

Relationship: _____ Phone: _____ Email: _____

Preferred language: _____ Preferred Pharmacy: _____

Medicare Card #: _____

Part A and B Effective Date: _____

Current Plan (If Any): _____

Do you have: Medicaid? ☐ **Yes** ☐ **No** Marital Status: ☐ **Single** ☐ **Married**

Please provide your monthly gross household income: _____

Are your total annual assets over $21,870? ☐ **Yes** ☐ **No**

LIST OF CURRENT PRESCRIPTION MEDICATIONS. Please do **not** include over-the-counter drugs.

MEDICATION NAME	DOSAGE/STRENGTH	HOW OFTEN TAKEN
EXAMPLE: Atorvastatin	20 mg	twice a day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

FOR OFFICE USE ONLY

Date MIF received: _____ **Assigned to: _____** **Current: $_____**

Date Assigned: _____ **Date MIF completed: _____** **Suggested $_____**

Date beneficiary contacted: _____ **Follow-up date (if mailed): _____** **TOTAL SAVINGS: $_____**

Comparison provided by: ☐ **Phone** ☐ **Mail** ☐ **Email**

Data Entry: ☐ **Excel log** ☐ **MIF scanned** ☐ **Peer Place** ☐ **STARS # _____**