

MPDPF Intake Form

To better assist you, we would like to collect the following information. The fields indicated by the * are required fields. If you have an inquiry about specific plans or pricing, please provide complete answers to all fields.

Counselor's Name*

1. Date of reported problem*
2. Time of reported problem*
3. Which search tool were you trying to use:*

 - Compare Plans
 - Enroll in a plan
 - Check Current Enrollment
 - Add/Update Drug & Pharmacy Information
 - Formulary Finder
 - Learn More about Plans in Your Area

4. Type of Search:
 - Personalized (and the following information if a personalized search is performed)
 - Name
 - Medicare number
 - Date of Birth
 - General
5. Part A Effective Date
6. Part B Effective Date
7. Zip Code
8. Subsidy Level:
 - Full
 - Partial
9. Save Work ID:
10. Save Work password date:
11. Specify the name, dosage and quantities of the drug(s) in question:
12. Plan Name(s) or Contract ID(s) and Plan ID(s) (format: S1234-001 or H1234-001)
13. Web page(s) title*
14. Server Number (located in the navy blue Medicare banner at the bottom left corner of the page):
15. Detailed description of the problem:*

* Required Field