

## Part D Troubleshooting Checklist

Client Identifying Information:

Name

Telephone

Address & zip code

Date of Birth

Advocate: Name & Telephone/Email

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MassHealth No. \_\_\_\_\_

Medicare No. \_\_\_\_\_

Medicare effective dates for Part A \_\_\_\_\_ for Part B \_\_\_\_\_

Prescription Advantage No. \_\_\_\_\_

Part D Plan Name \_\_\_\_\_

Pharmacy Name and Address

\_\_\_\_\_  
\_\_\_\_\_

Prescription: \_\_\_\_\_

Problem at pharmacy:

Efforts to resolve problem:

Did consumer leave pharmacy with drug? Y/N

How much did consumer pay for drug? \$\_\_\_\_

Other comments: