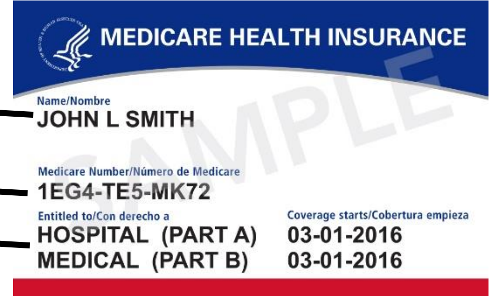
Medicare Prescription Drug Coverage Worksheet

SHICK Senior Health Insurance Counseling for Kansas

K-STATE Research and Extension | River Valley District

Please complete both sides of this form and return to the River Valley Extension District Office as soon as possible, but no later than one week before your appointment. Please bring any letters you received recently from Social Security and Medicare, as well as your current Medicare card, to your appointment.



1. **What is your name as it appears on your Medicare card?**

   ____

2. **What is your Medicare Claim Number?**

   ____

3. **What is the effective date for your Medicare?**

   Hospital (Part A) ________________________
   Month/Date/Year

   Medical (Part B) ________________________
   Month/Date/Year

4. **What is your date of birth?** ____________________
   Month/Date/Year

5. **What is your address?** ______________________

   City, State, Zip Code? ______________________

   Phone Number? ______________________

   Email Address? ______________________

   What county do you live in? ______________________

6. **List the pharmacy or pharmacies you use. Include the pharmacy name and city location.**

   ____

   ____

7. **Do you have a MyMedicare.gov account?**

   ______ Yes, it's already on file with Extension Office. Skip to Question 8.

   ______ Yes, my information is below.

   Username: ______________________ Password: ______________________

   Security Question: ______________________ Answer: ______________________

   ______ No, please create an account for me.

8. **Name of Current Part D Plan:** ____

Office Staff Use Only

Appt Date: ____________________

Appt Time: ____________________

Counselor: ____________________

Date Received in Office: ____________

MyMedicare.gov Information

Username: ____________________

Password: ____________________

Security Question: ______________

Answer: ____________________

MUST COMPLETE INFORMATION ON BACK

9. **List the prescription drugs you currently take. Be specific as possible. Include the dosage, type, and how often you take it per month. Print clearly. If you need additional space, please attach a piece of paper. You may attach a printout of your drugs from your doctor or pharmacy.**

Prescription Drug Name	**Dosage/Type** *Ex: 30 mg/capsule*	**30 Day Quantity** *Ex: 2 pills a day = 60*

Disclaimer: I confirm that all the information I have provided is truthful and accurate.

I give permission to the SHICK Counselors and River Valley Extension District staff to use my MyMedicare.gov username and password. If I do not have a MyMedicare.gov account set up, I give permission to the SHICK Counselors and River Valley Extension District staff to create a username, password, and security question. **I understand that I will receive a letter or email in the next few weeks stating that an account has been created for me.**

Signature: ______________________________ **Date:** ______________________________

For more information on SHICK or Medicare, please contact:
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