SHICK — Senior Health Insurance Counseling for Kansas — *Kansas Department on Aging*

K·STATE Research and Extension

# Medicare Prescription Drug Coverage Worksheet

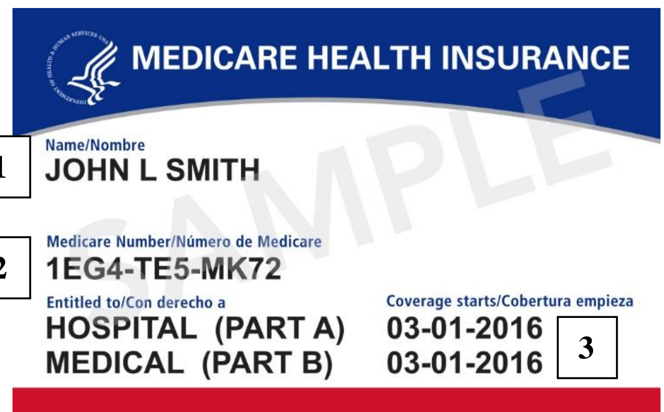
**Please Note:** Any information you provide us will be held in strictest confidence and will only by used to assist with Medicare enrollment assistance. We are honored to serve you!

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 of your Medicare?

Part A _______ / _______ / ________
Month date year

Part B _______ / _______ / ________
Month date year

4. What is your birth date?

__________ / _________ / _________
Month Date Year

5. Do you receive extra help in paying for your prescription medication(s)?

_____ Yes _____ No

6. Address: ______________________________________________

City: ________________ State: __________ Zip: ___________

7. Telephone Number: _______________________

8. What pharmacy do you prefer?

_______________________________________________

**Please List Prescription Drugs on Back** ⟶

- Please list the medications you are currently taking on a daily, weekly, or monthly basis.
- Please DO NOT list over the counter medicines, supplements, or vitamins.
- Please Print Clearly.
- *You may substitute a doctor or pharmacy typed listing of your drugs if all of the required information is included.*

| Drug Name as listed on container | Generic? Y/N | Strength | Quantity Per Month | 90 Day Supply? |
|---|---|---|---|---|
| Example: Synthroid | N | 100 mg | 30 | X |
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Please return to: Bernadette Trieb
PO Box 278
Alma, KS 66401

For Office Use Only

| **Date** | **Type of Visit** | **Time** | **Items discussed** |
|---|---|---|---|
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