

2026 Medicare Prescription Drug Coverage Worksheet

Please complete both sides of this form and return it to the Shawnee County Extension Office with your printed prescription medications. Once we receive your forms, we will contact you to schedule an appointment.

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



MEDICARE HEALTH INSURANCE

1 Name/Nombre
JOHN L SMITH

2 Medicare Number/Número de Medicare
1EG4-TE5-MK72

3 Entitled to/Con derecho a
HOSPITAL (PART A)
MEDICAL (PART B)

Coverage starts/Cobertura empieza
03-01-2016

2. What is your Medicare Number?

3. What is the effective date for your Medicare?

Hospital (Part A) effective date _____ Month/Date/Year

Medical (Part B) effective date _____ Month/Date/Year

4. What is your date of birth? _____ Current Age: _____
Month/Date/Year

5. What is your address? _____

City, State, Zip Code? _____

Phone Number? _____

Email Address? _____

What county do you live in? _____

Office Use Only

Date Received in Office: ____/____/2026

Appt Date: ____/____/2026

Time: ____: ____ am pm

Counselor: _____

6. List the pharmacy name where prefer to fill your prescriptions. Include the city if not Topeka.

1. _____

3. _____

2. _____

7. Do you use mail-order? Yes / No

8. How would you like to pay for the Part D prescription plan monthly premium? (check one)

___ I will pay the premium directly (EFT) OR ___ I want the premium taken from my Social Security benefit check

9. Do you have an online Medicare.gov account? Using your specific account will save your information for you.

Bring your log-in information, password, and dual authentication source (email, texting) if you want us to compare using your account.

10. What is your CURRENT Part D Prescription drug plan name? (Such as BCBS Essentials, Aetna SilverScript, Wellcare Value Script, etc)

11. What is your CURRENT monthly premium for your CURRENT drug plan? \$ _____/month

← PLEASE COMPLETE INFORMATION ON BACK →

- 12. Please attach a printout of your prescription drugs from your doctor, MyChart, or pharmacy for best accuracy.**
Do not include over-the-counter medications such as vitamins or supplements. If you only have a few prescription medications, you may list the prescription drugs you currently take below. Be as specific as possible by including the dosage, type, and how often you take it per month.

PLEASE PRINT CLEARLY

<u>Prescription Drug Name</u> exactly as it appears on your Rx label, include any letters or numbers behind the prescription name (i.e. TR, ER) PLEASE PRINT CLEARLY	<u>Dosage/Type</u> <i>Example: 30 mg/capsule .05 mcg/tablet</i>	<u>30 Day Quantity</u> <i>Example: 2 pills a day = 60 qty</i>	<u>Injection or Inhaler?</u> <i>How many pens do you pick up per month? How often do you pick up a new inhale each monthr?</i>

- 13. Is your total gross income (amount before deductions) below these guidelines?** ___ Yes ___ No
Individual -- \$1,995 **OR** Married Couple-- \$2,705

- 14. Are your resources/assets below these guidelines?** ___ Yes ___ No
(bank and retirement accounts, stock/bonds, etc. DO NOT include primary residence and vehicle)
Individual- \$23,940 **OR** Married Couple-- \$32,460

- 15. Initial Disclaimer:** _____ I confirm that all the information I have provided is truthful and accurate.
I give permission to the SHICK Counselors and Shawnee County Extension Office to use my Medicare.gov username and password. If I do not have a www.Medicare.gov account, I give permission to the SHICK Counselors and Shawnee County Extension 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 a Medicare.gov account has been created for me.**

Signature: _____ **Date:** _____

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