2026 Medicare Prescription Drug Coverage Worksheet

SHICK Senior Health Insurance Counseling for Kansas

Kansas State University Extension Shawnee County

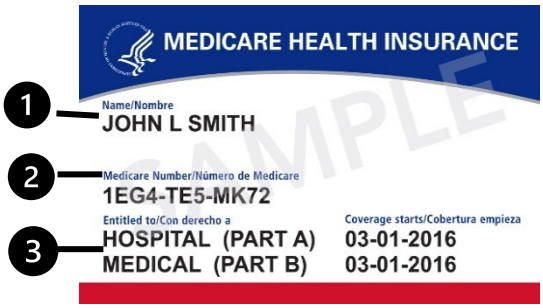
Please complete both sides of this form and **return it to the Shawnee County Extension Office with your printed prescription medications**. Once we receive your forms, **we will contact you to schedule an appointment**.

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

   _____

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

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

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**:** _____