SHICK Senior Health Insurance Counseling for Kansas

NorthWest Kansas
Area Agency on Aging
510 W. 29th, Ste. B
Hays, KS 67601

1-800-432-7422 1-785-628-8204

MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

1. What is your name as it appears on your Medicare card①?

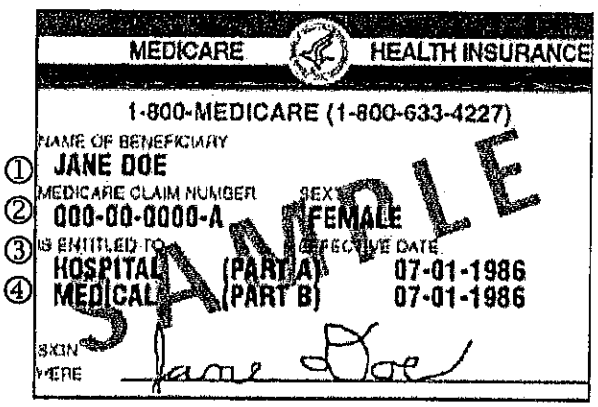
   _____

2. What is your Medicare Claim Number②?

   _____

3. What is your date of birth?

   _____/_____/_____



4. What is the effective date for your Medicare?

   Part A③ _____/_____/_____
   Month Date Year

   Part B④ _____/_____/_____
   Month Date Year

5. What is your zip code?

   _____

6. What county do you live in?

   _____

7. What is your address?

   _____

   _____

   Phone # (_____) _____

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8. Which drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). PLEASE PRINT CLEARLY

DRUG NAME	DOSAGE	30- DAY QUANITY	MONTHLY COST

9. Is there a pharmacy you prefer to use? (If yes, list pharmacy below)

_____