MEDICARE PRESCRIPTION DRUG COVERAGE
Personal Information Worksheet

NAME:_____

ADDRESS:_____ ZIP_____

PHONE:_____

MEDICARE NUMBER:_____ Part A Effective Date:_____

BIRTH DATE:_____ Part B Effective Date:_____

(We cannot complete the drug plan comparison without the information above)

Do you have prescription coverage through a former employer? Yes_____ No_____

Are your prescriptions covered by Medicaid? _____ (low income–through SRS)

Is your Medicare Part B premium paid for by Medicaid?_____

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Are you new to Medicare?_____

If you currently have plan D coverage, which company are you with?_____

What pharmacy do you prefer to use?_____

Are you willing to use another pharmacy if it will save you more money? ___ Yes ____ No

Are there any pharmacies you will not use?_____

LIST PRESCRIPTION DRUGS YOU ARE TAKING, including dosage: Please print

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

For 2018 you must bring or mail completed form to Jennifer Wilson, % Riley County Extension, 110 Courthouse Plaza, Rm B220, Manhattan, KS 66502 or sriffey@ksu.edu. You will then be called to schedule an appointment if necessary. Please make sure you complete all blanks.