OMB No. 0938-1441
Expires: 11/30/2024

APPLICATION FORM TO ENROLL IN THE LIMITED INCOME NET (LI NET) PROGRAM

What is the Limited Income NET (LI NET) program?

LI NET is a Medicare program that gives temporary prescription drug coverage for people with Medicare who qualify for low-income subsidy (LIS) or "Extra Help" and have no prescription drug coverage.

Fill out this form to enroll in this program

- Complete Section 1 and include one of the documents from the list of acceptable supporting documentation.
- Send the information either by mail to <
  LI NET
  P.O. Box 14310
  Lexington, KY 40512-4310

  fax to <1-877-210-5592>,

When should I use this form?

Use this form if you haven't enrolled through any of these ways:

- Automatic enrollment by the Centers for Medicare and Medicaid Services (CMS)
- Point of sale enrollment at a pharmacy
- Direct reimbursement request for prescription drugs that you paid for out of pocket

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)

Your permanent address* and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional - you can't be denied coverage because you don't fill out.

What happens next?

After we process your enrollment, you'll get a welcome letter with information and instructions.

For help with this form

Call the LI NET help desk at <1-800-783-1307>. TTY users can call <711>.

Go to <humana.com/linet>.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a <Humana> al <1-800-783-1307> o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

If you're experiencing homelessness

- If you want to enroll in LI NET but don't have a permanent residence, you can list a Post Office Box, an address of a shelter or clinic, or the address where you get mail (like your Social Security checks) as your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)			
FIRST name:	LAST name:		Middle initial (optional):
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )	
Permanent Residence street address (Don't enter a P.O. Box..):			
City:	County (optional):	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed): Street address:	City:	State:	ZIP code:
Your Medicare information:			
Medicare Number:	_ _ _ _ - _ _ _ - _ _ _ _		
Information submitted by: ☐ Self ☐ Caregiver/Patient Advocate ☐ Other			
Name (if other than person with Medicare):			
Phone number: ( )			

You have the <u>option</u> to provide one of these documents with your application to support verification of eligibility. This documentation may include:

(A) A copy of your Medicaid card

(B) A copy of a letter from the State or Social Security Administration showing your low-income subsidy (LIS) or "Extra Help" status

(C) The date you called your State Medicaid agency to verify your Medicaid coverage, the name and phone number of the State staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call

(D) A copy of a document from your State that confirms your Medicaid status is active

(E) A screen-print from your State's Medicaid systems showing your Medicaid status

(F) Proof from a pharmacy that they billed Medicaid and that Medicaid made a payment to it

(G) Documentation of enrollment in other benefits such as Supplemental Security Income (SSI)

Section 2 (Optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White
☐ **I choose not to answer.**

Select a language below if you want us to send you information in a language other than English.

☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact <LI NET> at <1-800-783-1307> if you need information in an accessible format other than what's listed above. Our office hours are <Monday – Friday 8 a.m. – 7 p.m., Eastern time>. TTY users can call <711>.

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan