



Indiana's Prescription Drug Program for Seniors



State Form 49905 (R11/2-09) PDP 0001

HoosierRx helps pay up to \$70 each month for your Medicare Part D premiums.

To be eligible, you must:

- Be an Indiana resident, age 65 or older
- Have income at or below \$16,485 (single) or \$22,095 (married) and not eligible for Full Medicare Extra Help
- Have received a "Notice of Award" or "Notice of Denial" for Medicare Extra Help from Social Security
- Be enrolled in a Medicare Part D plan that works with HoosierRx

For a list of Medicare Part D companies working with HoosierRx call us toll free at 1-866-267-4679 or visit our web site at www.IN.gov/HoosierRx

Application For HoosierRx

Helping Seniors with Medicare Prescription Drug Plan Costs
This application continues on the back side.

Who is applying for the HoosierRx program? Just you You and your spouse

Information About You

Name of applicant (first name, middle initial, last name)		Telephone number (include area code) ()	
Date of birth (month, day, year)	Social Security number of applicant	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home mailing address (number and street)	City	State	ZIP Code
Race (optional)	Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
Other mailing address (if different) (other authorized name, number, street, city, state, ZIP code) - P.O.A. send proof			
Other telephone number (include area code) ()			

Information About Your Spouse (If married and living together, you must complete this section and send copies of the monthly income for you and your spouse, even if only one is applying for benefits.)

Name of spouse (first name, middle initial, last name)	Date of birth of spouse (month, day, year)
Social Security number of spouse	Race of spouse (optional)

Medicare Extra Help + HoosierRx Help

- To be eligible for help from HoosierRx, you must have first applied for Medicare Extra Help with your Medicare Prescription Drug Plan Costs through the Social Security Administration.
- You may be eligible for HoosierRx help if you have been found eligible for partial Medicare Extra Help.
- You may also be eligible for HoosierRx help if you have been denied Medicare Extra Help because of your resources.
- If you receive full Medicare Extra Help you are not eligible for HoosierRx help.

***You must attach a copy of your "Notice of Award" or "Notice of Denial" from Social Security**

Have you applied for Medicare Extra Help? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse applied for Medicare Extra Help? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please take out your Medicare Card to complete this section
Please fill in these blanks so they match your red, white and blue Medicare card.

MEDICARE



HEALTH INSURANCE

YOU

First Name _____
 Middle Initial _____
 Last Name _____
 Medicare Claim Number
 _____ - _____ - _____
 Is Entitled to Effective Date
 HOSPITAL (Part A) ___/___/___
 HOSPITAL (Part B) ___/___/___

MEDICARE



HEALTH INSURANCE

YOUR SPOUSE (if applying)

First Name _____
 Middle Initial _____
 Last Name _____
 Medicare Claim Number
 _____ - _____ - _____
 Is Entitled to Effective Date
 HOSPITAL (Part A) ___/___/___
 HOSPITAL (Part B) ___/___/___

Income (Important to Read)

- If Social Security denied you for Medicare Extra Help, you must complete the section below and attach papers to prove your income (example: your bank statement or a copy of your Social Security check.)
- If Social Security has found you eligible for any Medicare Extra Help, you do not need to complete the income section and do not need to attach proof of income.

Types of Income You May Receive

Enter the amount you get each month

Social Security or Railroad Retirement income
 Pensions, retirement income, annuities, veteran's benefits
 Other income: wages, rental income, interest and dividends

Applicant (You)

Spouse

\$	\$
\$	\$
\$	\$
\$	\$

Please attach copies of proof of income. TOTAL

- To receive HoosierRx Help, you must be enrolled in a Medicare Part D Plan working with HoosierRx.
- Enter your Medicare Part D Plan information from your Medicare Part D Drug Card or "Welcome Letter" below:

YOUR Medicare Part D Plan

Plan Name _____
 ID Number _____

YOUR SPOUSE'S Medicare Part D Plan

Plan Name _____
 ID Number _____

Please attach a copy of your (and your spouse's) Medicare Part D ID card or welcome letter.

I understand that I/we must complete this application in full or this application will not be accepted. I understand that the information I/we provide is confidential and will not be disclosed without my consent for any purpose that is not related to HoosierRx (PL 42 USC 405(c)(2)(C)(i)/IC 4-1-6-2/IC 4-1-8-2). I authorize Medicaid to release information about Medicaid eligibility to HoosierRx. I will inform HoosierRx if I disenroll or change my Medicare Part D Plan. I reside permanently in Indiana. I certify, under penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge.

Signature of applicant X	Signature of spouse (if applying) X	Date (month, day, year)
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Be sure that you:



- Attach a copy of your "Notice of Award" or "Notice of Denial" from Social Security
- Attach a copy of your Medicare Part D Card or welcome letter showing your ID number
- Include papers to show proof of your income with your application
- Sign the application

Send your application, and other papers to:

HoosierRx
 P.O. Box 6224
 Indianapolis, IN 46206-6224
 or fax them to: 317-234-3709

Questions? Call us toll-free at 1-866-267-4679 or visit our website at www.IN.gov/HoosierRx