Form Approved
OMB No. 0938-1428
Expires:xx/xx

APPLICATION FOR ENROLLMENT IN PART B IMMUNOSUPPRESSIVE DRUG COVERAGE

WHAT IS PART B IMMUNOSUPPRESSIVE DRUG COVERAGE (PART B-ID)?

The Part B-ID benefit coverage is only available to individuals who are entitled to Medicare based on End-Stage Renal Disease (ESRD) and are losing Medicare entitlement 36 months after a kidney transplant. The benefit is coverage solely for immunosuppressive drugs under Medicare Part B.

ARE THERE STATUTORY EXCLUSIONS?

Congress has excluded certain individuals from receiving Part B-ID. If you have certain other coverage, you are not eligible for this benefit. Excluded coverage includes:

- Employer Group Health Plan or Individual Health Plan. (These plans are defined in section 2791 of the Public Health Service Act).
- TRICARE for Life (This program is established at 10 USC 1086(d).
- Medicaid (Title XIX of the Social Security Act) or State Children's Health Insurance Program (CHIP) (Title XXI of the Social Security Act) if such coverage includes immunosuppressive drugs
- Being enrolled in the patient enrollment system of the Department of Veterans Affairs (VA) (38 USC 1705) or otherwise eligible to receive immunosuppressive drugs from the VA

NOTE: If you enroll in any excluded health insurance coverage, you must notify the Social Security Administration (SSA) within 60 days of obtaining that health insurance coverage.

WHO CAN USE THIS FORM?

Use this form if you or your child/dependent had a kidney transplant and have lost or will be losing their Medicare coverage that was based on ESRD 36 months after their kidney transplant.

NOTE: If you or your child/dependent have other health coverage, or you or your child/dependent have Medicaid or State Children's Health Insurance Program (CHIP) that covers immunosuppressive drugs, do not complete this form.

WHEN DO YOU USE THIS FORM?

You should use this form:

- If you or your child/dependent have lost or will be losing Medicare coverage that was based on ESRD 36 months after a kidney transplant, and you/they want to enroll in the Part B-ID benefit for coverage of immunosuppressive drugs.
- If you or your child/dependent are not enrolled in any other health insurance coverage (except Medicaid or CHIP that does not cover immunosuppressive drugs).
- If you or your child/dependent do not expect to enroll in any other health insurance coverage (except Medicaid or CHIP that does not cover immunosuppressive drugs).
- You do not currently have Medicare based on being age 65 or older or based on having a disability.

WHEN CAN YOU ENROLL?

Enrollment in Part B-ID can begin two months prior to the termination of your Medicare based on ESRD or anytime after ESRD termination. If you enroll prior to the termination of your Medicare based on ESRD, your Part B-ID benefit will begin the month after ESRD Medicare termination. If you enroll in Part B-ID after your ESRD Medicare termination, Part B-ID will begin the month following the enrollment.

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS FORM?

- Applicant's Medicare Number or Social Security Number
- Applicant's current address and phone number

HOW DO YOU SUBMIT THE FORM?

Complete and sign page 2 of this form and send it to Social Security Administration Office of Central Operations, PO Box 32914, Baltimore, Maryland 21298. You can apply for this benefit by calling **1-877-465-0355**.

HOW DO YOU GET HELP WITH THIS FORM?

- Call Social Security at **1-800-772-1213**. TTY users can call **1-800-325-0778**.
- Contact your local field office. Find an office near you at **www.ssa.gov**.
- En español: Llame a SSA gratis al 1-800-772-1213 y oprima el 7 si desea el servicio en español y espere a que le atienda un agente.

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1. Medicare Number/SSN

2. Your Name (Last Name, First Name, Middle Name)

3. Mailing Address (Number and Street, P.O. Box, or Route)

City | State | Zip Code

4. Permanent Address (if different from mailing address)

City | State | Zip Code

5. Phone Number (including area code)

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By using this form to enroll in the Part B-ID benefit for immunosuppressive drug coverage I attest that:

☐ Yes ☐ No I am not enrolled in, and do not expect to enroll in certain, other health insurance coverage, and I will notify Social Security within 60 days if I enroll in other health insurance coverage.

*Please refer to page 1 for a complete description of the health insurance coverage that would preclude Part B-ID coverage.

I understand that anyone who, knowingly and willfully —
(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
or
(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined or imprisoned not more than 5 years, or both.[1]

Signature (DO NOT PRINT)
SIGN HERE

Date Signed
☐☐ / ☐☐ / ☐☐☐☐

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

Signature of Witness

Date Signed
☐☐ / ☐☐ / ☐☐☐☐

Address of Witness

[1] 18 U.S. Code § 1035 - False statements relating to health care matters
(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully—
(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
or
(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.
(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS APPLICATION

1. **Applicant's social security number (or applicant's Medicare Number):** Enter your Social Security Number, or if you already have Medicare, you can enter your Medicare Number instead.

2. **Name:** Enter your name. List your last name, first name, and middle name (if you have one) in that order.

3. **Mailing address:** Enter your full mailing address, including the number and street name, city, state, and ZIP code. You can enter a P.O. Box or route.

4. **Address of permanent residence:** If you live at a different address than where you get mail, enter the full address, including the number and street name, city, state and ZIP code.

5. **Phone number:** Enter your daytime phone number in case a representative needs to contact you for additional information.

Enrollment in the Part B-ID Benefit

Check the box to attest that you meet the requirements for entitlement to the Part B-ID benefit.
Refer to page 1 under the description of Other Health Insurance Coverage.

PRIVACY ACT STATEMENT: Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you're entitled to Part B. While you don't have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment.

Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS and in accordance with System of Records Notice (SORN) "HHS/CMS/CBC Enrollment Database", System No. 09-70-0502, 73 Federal Register 10249, February 26th, 2008 and as permitted by the Privacy Act of 1974, to:

1) Determine your rights to Social Security benefits and/or Medicare coverage.
2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration)
3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

PRA DISCLOSURE STATEMENT: 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 0938-1428. The time required to complete this information collection is estimated to average 10 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 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.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Social Security Administration at 1-800-772-1213. TTY users can call 1-800-325-0778.