OMB No. 0938-1441
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APPLICATION FORM TO ENROLL IN THE LIMITED INCOME NEWLY ELIGIBLE TRANSITION (LI NET) PROGRAM

What is the Limited Income Newly Eligible Transition (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 sponsor address>, fax to <LI NET sponsor fax number>, or email to <LI NET sponsor email address>.

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

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 <LI NET sponsor phone number>. TTY users can call <phone number/TTY>.

Go to <LI NET sponsor website>.

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

En español: Llame a <LI NET sponsor name> al <phone number/TTY> o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

If you're experiencing homelessness

- *If you want to enroll in LINET 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.

PRA Disclosure Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare sponsors to track beneficiary enrollment, 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. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law.

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 0938-1441. The time required to complete this information is estimated to average 15 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 see "For help with this form" on this page to send your completed form to the LI NET sponsor.

Section 1			
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 option 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

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, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **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.

☐ *[LI NET sponsor to insert the languages required in its service area.]*

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 sponsor name> at <LI NET sponsor phone number> if you need information in an accessible format other than what's listed above. Our office hours are <LI NET sponsor's days and hours of operation>. TTY users can call <TTY number>.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

☐ [*LI NET sponsor may list those types or categories of materials that are available for electronic delivery]*

E-mail address: