

DIRECT REIMBURSEMENT REQUEST FOR 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.

Ways people get enrolled into the LI NET program:

- Automatic enrollment by the Centers for Medicare and Medicaid Services (CMS)
- Point-of-sale enrollment at a pharmacy
- LI NET application form
- Humana gets this direct reimbursement request from you

When should I use this form?

Use this form if you’re eligible for a low-income subsidy and are submitting receipts to request reimbursement 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
- Receipt(s)

What happens next?

Send the information either by mail to: **LI Net Program P.O. Box 14310 Lexington, KY 40512-4130** or fax to **877-210-5592**.

Humana has 14 calendar days to reply whether your request is eligible or not for reimbursement, including the reason for denying the request (if applicable). If Humana grants your request, it will:

- Send you your reimbursement check no later than 30 days after it determines your claim is eligible for reimbursement
- Retroactively enroll you into the LI NET program.

For help with this form

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

Go to **humana.com/linet** .

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

En español: Llame a Humana al **800-783-1307** (TTY **711**) o a Medicare gratis al **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 get reimbursed and 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.

Prescription Drug Claim Form for Member Reimbursement

Section 1: Member Information

Section 1 Instructions:

1. Complete this section fully and submit this request within the filing period which is **36 months from the date the prescription is filled**. For questions about the filing period, please call the LINET helpdesk at **800-783-1307** (TTY users dial **711**);
2. If submitting a request where medications were obtained from multiple pharmacies or physicians or a request is for multiple members, please submit a separate form for each pharmacy or physician and member.

<u>Member ID Number (required):</u>		<u>Medicare ID Number:</u>	
<u>Member Name (Last, First, MI):</u>		<u>Date of Birth (mm/dd/yyyy):</u>	
<u>Street Address:</u>		<u>Phone Number:</u>	
<u>City:</u>	<u>State:</u>	<u>Zip Code:</u>	
<u>Gender:</u>	<u>Person Completing Form:</u> <input type="radio"/> Member <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other: _____		
<u>Patient Residence:</u> <input type="radio"/> Home <input type="radio"/> Nursing Home <input type="radio"/> Assisted Living <input type="radio"/> Immediate Care <input type="radio"/> Hospice			

Is the member eligible for primary prescription drug coverage from another insurance provider? N Y

If yes: Was the claim submitted to the other insurance provider? N Y

Did the other insurance provider pay as the primary insurer? N Y

Name of other insurance provider: _____ Member ID: _____

Section 2: Pharmacy and Provider Information

Section 2 Instructions:

1. Provide the requested information about the pharmacy where medications were received AND the doctor that prescribed them;
2. Your pharmacy and doctor will be able to assist you if you are missing any of this information.

Pharmacy Information

<u>Pharmacy Name:</u>		<u>Pharmacy NCPDP or NPI:</u>	
<u>Street Address:</u>		<u>Phone Number:</u>	
<u>City:</u>	<u>State:</u>	<u>Zip Code:</u>	
<u>Pharmacy Service Type:</u> <input type="radio"/> Retail <input type="radio"/> Compounding <input type="radio"/> Home Infusion <input type="radio"/> Institutional <input type="radio"/> Long-term Care <input type="radio"/> Manage Care Organization <input type="radio"/> Mail Order <input type="radio"/> Specialty			

