OMB No. 0938-1441
Expires: 11/30/2027

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
P.O. Box 14310
Lexington, KY 40512-4310
or fax to 1-877-210-5592

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 1-800-783-1307. TTY users can call 711.

Go to humana.com/LINETresources.

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

En español: Llame a la mesa de ayuda de LI NET al 1-800-783-1307. Los usuarios de TTY pueden llamar al 711 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 get reimbursed and 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.

LINET
LIMITED INCOME NET PROGRAM

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.

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

Pharmacy Name:	Pharmacy NCPDP or NPI:	
Street Address:	Phone Number:	
City:	State:	Zip Code:
Pharmacy Service Type: ◯ Retail ◯ Compounding ◯ Home Infusion ◯ Institutional ◯ Long-term Care ◯ Manage Care Organization ◯ Mail Order ◯ Specialty		

Prescription Drug Claim Form for Member Reimbursement

Physician Information

Physician Name:	Physician NCPDP or NPI:	Physician Tax ID:
Street Address:	Phone Number:	
City:	State:	Zip Code:

Section 3: Prescription Drug Information

Section 3 Instructions:

1. Fill out the space below completely for **EACH** requested medication. If any information is missing, we will be unable to process your request. Your pharmacy can provide any information you are missing;
2. Include pharmacy receipt(s) **AND** proof of payment. Tape receipts to a separate page and submit with claim form. If medication was given in the emergency room or doctor's office include detailed statement.

Note: Services incurred outside the United States are not payable under Medicare plans.

Is this a compound medication? ◯ No ◯ Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯ Yes			
Is this a vaccine? ◯ No ◯ Yes	*If yes:* Vaccine Cost: $_____ Admin Fee: $_____		
National Drug Code (NDC)	Drug Name:	Total Cost: $	
Fill Date (mm/dd/yyyy):	Rx Number:	Qty:	Day Supply:
Dosage Form	Strength:	Dispense as Written Code (if applicable):	

Is this a compound medication? ◯ No ◯ Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯ Yes			
Is this a vaccine? ◯ No ◯ Yes	*If yes:* Vaccine Cost: $_____ Admin Fee: $_____		
National Drug Code (NDC)	Drug Name:	Total Cost: $	
Fill Date (mm/dd/yyyy):	Rx Number:	Qty:	Day Supply:
Dosage Form	Strength:	Dispense as Written Code (if applicable):	

Prescription Drug Claim Form for Member Reimbursement

Is this a compound medication? ◯No ◯Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯Yes			
Is this a vaccine? ◯ No ◯Yes	*If yes:* Vaccine Cost: $_____	Admin Fee: $_____	
National Drug Code (NDC)	Drug Name:	Total Cost: $	
Fill Date (mm/dd/yyyy):	Rx Number:	Qty:	Day Supply:
Dosage Form	Strength:	Dispense as Written Code (if applicable):	

Is this a compound medication? ◯No ◯Yes *If yes, please attach compound form from pharmacy if available*			
Was this prescription filled outside the US? ◯ No ◯Yes			
Is this a vaccine? ◯No ◯Yes	*If yes:* Vaccine Cost: $_____	Admin Fee: $_____	
National Drug Code (NDC)	Drug Name:	Total Cost: $	
Fill Date (mm/dd/yyyy):	Rx Number:	Qty:	Day Supply:
Dosage Form	Strength:	Dispense as Written Code (if applicable):	

If additional space is needed, you may access a blank drug information form from our website at: **https://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms**

Section 4: Reason for Request

- ☐ Pharmacy will not accept my Humana Plan
- ☐ I did not have my plan information at the time of purchase
- ☐ I was charged for medications receive during and ER visit
- ☐ I believe the claim was paid incorrectly
- ☐ I received a medication while on a cruise **(Cruise itinerary must be included with request)**
- ☐ I received a Part D covered vaccine in my doctor's office
- ☐ I filled my medication during a natural disaster or state of emergency
- ☐ Other:_____

Please further explain the issue: _____

IMPORTANT CLAIM NOTICE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

Section 5: Sign and Return

NOTE: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at **https://www.humana.com/member/documents-and-forms** for your convenience.

Member Signature:_____ Date: _____

Return the completed **form** and **receipt(s)**:

Mail: LI NET Program
P.O. Box 14310
Lexington, KY 40512-4130

Fax: 877-210-5592

Notice of Non-Discrimination

The Limited Income NET (LI NET) Program complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. LI NET:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **<800-783-1307 (TTY: 711)**, Monday through Friday, 8 a.m. to 7 p.m., Eastern time>. If you believe that LI NET has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, or email with LI NET's Non-Discrimination Coordinator at **P.O. Box 14618, Lexington, KY 40512-4618, 800-783-1307 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, LI NET's Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**

California members:

California residents: You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

If you need help with a grievance that has not been resolved by Humana or is unresolved for more than 30 days, you may call the California Department of Managed Healthcare at **888-466-2219** or **TDD 877-688-9891**, or visit the California Department of Managed Healthcare website: **www.dmhc.ca.gov**.

This notice is available at **https://www.humana.com/member/medicare-linet-pharmacy-resources**.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **800-783-1307 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **800-783-1307 (الهاتف النصي: 711)**.

Հայերեն Armenian: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **800-783-1307 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **800-783-1307 (TTY: 711)** নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **800-783-1307（听障专线：711）**。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **800-783-1307**（聽障專線：**711**）。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **800-783-1307 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **800-783-1307 (TTY: 711)**.

فارسی Farsi: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **800-783-1307 (TTY: 711)** تماس بگیرید.

Français French : Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **800-783-1307 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **800-783-1307 (TTY: 711)**.

Ελληνικά Greek: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **800-783-1307 (TTY: 711)**.

ગુજરાતી Gujarati: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **800-783-1307 (TTY: 711)** પર કૉલ કરો.

עברית Hebrew: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **800-783-1307 (TTY: 711)**

Hmoob Hmong: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **800-783-1307 (TTY: 711)**.

Italiano Italian: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **800-783-1307 (TTY: 711)**.

This notice is available at **http://www.humana.com/legal/multi-language-support**.

GCHMKFREN

日本語 Japanese:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**800-783-1307 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ Khmer៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **800-783-1307 (TTY: 711)**។

한국어 Korean: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
800-783-1307 (TTY: 711) 번으로 문의하십시오.

Diné: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníígíí diné bich’į’ anídahazt’i’í, dóó ahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **800-783-1307 (TTY: 711)**.

Polski Polish: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **800-783-1307 (TTY: 711)**.

Português Portuguese: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **800-783-1307 (TTY: 711)**.

ਪੰਜਾਬੀ Punjabi: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **800-783-1307 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

Русский Russian: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **800-783-1307 (TTY: 711)**.

Español Spanish: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **800-783-1307 (TTY: 711)**.

Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **800-783-1307 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **800-783-1307 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **800-783-1307 (TTY: 711)** కి కాల్ చేయండి.

اردو Urdu: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 800-783-1307**

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **800-783-1307 (TTY: 711)**.