OMB No. 0938-1441
Expires: 11/30/2024

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 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.

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.

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		

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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):	

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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