Indiana's Prescription Drug Program for Seniors

State Form 49905 (R24 / 3-22)

Clear Form

HOOSIER Rx

HoosierRx helps pay up to $70 each month for your Medicare Part D premiums.

To be eligible, you must:

- Be an Indiana resident, age 65 or older
- For 2022, have income at or below $20,625 (*single*) or $27,705 (*married*) and not eligible for Full Medicare Extra Help
- Have received a "Notice of Award" or "Notice of Denial" for Medicare Extra Help from Social Security
- Be enrolled in a Medicare Part D plan that works with HoosierRx

For a list of Medicare Part D companies working with HoosierRx call us toll free at 1-866-267-4679 or visit our website at http://at.in.gov/HoosierRx

Application For HoosierRx

Helping Seniors with Medicare Prescription Drug Plan Costs

This application continues on the back side.

Who is applying for the HoosierRx program? ☐ Just you ☐ You and your spouse

Information About You

Name of applicant (*first name, middle initial, last name*)	Telephone number (*include area code*) ( )

Date of birth (*month, day, year*)	Social Security number of applicant	Check One ☐ Male ☐ Female

Home mailing address (*number and street*)	City	State	ZIP Code

Race *(optional)*	Marital Status ☐ Single ☐ Married ☐ Widowed

Other mailing address (*if different*) (*other authorized name, number, street, city, state, ZIP code*) – P.O.A. send proof

Other telephone number *(include area code)* ( )	Email address

Information About Your Spouse

(*If married and living together, you must complete this section and send copies of the monthly income for you and your spouse, even if only one is applying for benefits.*)

Name of spouse (*first name, middle initial, last name*)	Date of birth of spouse (*month, day, year*)

Social Security number of spouse	Race of spouse (*optional*)

Medicare Extra Help + HoosierRx Help

- To be eligible for help from HoosierRx, you must have first applied for Medicare Extra Help with your Medicare Prescription Drug Plan Costs through the Social Security Administration.
- You may be eligible for HoosierRx help if you have been found eligible for partial Medicare Extra Help.
- You may also be eligible for HoosierRx help if you have been denied Medicare Extra Help because of your resources.
- If you receive full Medicare Extra Help you are not eligible for HoosierRx help.
- If you are on Medicaid you are not eligible for HoosierRx help.

Have you applied for Medicare Extra Help? ☐ Yes ☐ No	Has your spouse applied for Medicare Extra Help? ☐ Yes ☐ No

Please take out your Medicare Card to complete this section
Please fill in these blanks so they match your red, white and blue Medicare card.

MEDICARE HEALTH INSURANCE

YOU

First Name _____
Middle Initial _____
Last Name _____
Medicare Number
___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Is Entitled to	Effective Date
HOSPITAL (Part A)	____/____/_____
HOSPITAL (Part B)	____/____/_____

MEDICARE HEALTH INSURANCE

YOUR SPOUSE *(if applying)*

First Name _____
Middle Initial _____
Last Name _____
Medicare Number
___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Is Entitled to	Effective Date
HOSPITAL (Part A)	____/____/_____
HOSPITAL (Part B)	____/____/_____

Income (*Important to Read*)

- If Social Security denied you for Medicare Extra Help, you must complete the section below and attach papers to prove your income (*example: your bank statement*).
- If Social Security has found you eligible for any Medicare Extra Help, you do not need to complete the income section and do not need to attach proof of income.

Types of Income You May Receive *Enter the amount you get each month*	**Applicant (*You*)**	**Spouse**
Social Security or Railroad Retirement income	$	$
Pensions, retirement income, annuities, veteran's benefits	$	$
Other income: wages, rental income, interest and dividends	$	$
Please attach copies of proof of income, such as a recent bank statement showing deposits. **TOTAL**	**$** 0.00	**$** 0.00

- To receive HoosierRx Help, you must be enrolled in a Medicare Part D Plan working with HoosierRx.
- Enter your Medicare Part D Plan information from your Medicare Part D Drug Card or "Welcome Letter" below:

YOUR Medicare Part D Plan		**YOUR SPOUSE'S Medicare Part D Plan**	
Plan Name		Plan Name	

I understand that I/we must complete this application in full or this application will not be accepted. I understand that the information I/we provide is confidential and will not be disclosed without my consent for any purpose that is not related to HoosierRx (*PL 42 USC 405(c)(2)(C)(i)/IC 4-1-6-2/IC 4-1-8-2*). I authorize Medicaid to release information about Medicaid eligibility to HoosierRx. I will inform HoosierRx if I disenroll or change my Medicare Part D Plan. I reside permanently in Indiana. I certify, under penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge.

Signature of applicant	Signature of spouse (*if applying*)	Date (*month, day, year*)
X	**X**	

Be sure that you:

- ☐ Attach a copy of your "Notice of Award" or "Notice of Denial" from Social Security
- ☐ Include papers to show proof of your income
- ☐ Sign the application

Send your application, and other papers to:
HoosierRx
402 W. Washington St., Room W374, MS07
Indianapolis, IN 46204
or fax them to: 317-234-3709

Questions? Call us toll-free at 1-866-267-4679 or visit our website at http://at.in.gov/HoosierRx