State Form 49905 (R26 / 3-24)

Indiana's Prescription Drug Program for Seniors

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 2024, have income at or below $22,830 (*single*) or 30,900 (*married*)
- 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://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*)	Check One ☐ Male ☐ Female

Home mailing address (*number and street*)	City	State	ZIP Code
Race *(optional)*	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated		

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*)
Phone Number of Spouse *(include area code)* ( )	Race of spouse (*optional*)

Continues on back side

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 (You must provide your gross income from all sources as well as verification of income for application to be processed)

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	$	$
TOTAL	**$** 0.00	**$** 0.00

Please attach copies of proof of income, such as a recent bank statement showing deposits.

- To receive HoosierRx Help, you must be enrolled in a Medicare Part D Plan working with HoosierRx.
- Enter the name of your Part D Plan from your Prescription Drug Card.

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:

☐ **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://in.gov/HoosierRx