

Patient Assistance Program for Medicare Beneficiaries

Application Instructions

Patients wishing to be considered for eligibility must submit a completed application along with proof of income and prescription drug expenses (see below).

Section 1 – Physician and Prescription Information

All physician information must be completed. Prescription information may be entered or attached. Physician signature is required.

Section 2 – Patient Information

This section must have all patient information completed.

Section 3 – Financial Information

Patients must list all sources of income and attach proof of income. Please attach a copy of the patient's most recent federal income tax return. The program accepts copies of **IRS Forms 1040, 1040A, 1040EZ, 1040X, 1040NR-EZ, IRS Telefile, 8453, 8879, 1722 (transcript), Federal Tax Transcript, Federal Recap Form**

If the patient has not filed a federal income tax return in the previous sixteen (16) months, please submit a copy of **each** of the following that apply:

- IRS Form 4506T
- W-2 Tax Statement
- Pension Statements
- Disability Statements
- Social Security Checks/Statements
- Railroad Retirement Statements
- Statements of Interest, Dividends or other Income (1099-INT, 1099, 1099T, 1099DIV)

Section 4 Social Security Low Income Subsidy

Patients must complete this section.

****If the patient has applied for the Medicare Part D Low Income Subsidy (also known as “Extra Help”) through the Social Security Administration within the past year and has been denied, please attach a copy of the denial letter.**

Section 5 – Prescription Drug Information

Patients must complete all four insurance boxes and enter the total amount that they have spent (out-of-pocket) for prescriptions in the current calendar year (i.e., since January 1). **The program requires that a patient must have spent at least 3% of their annual household income on prescriptions during the current calendar year. Only prescription costs in the current calendar year will be considered. Please attach a copy of the most current Explanation of Benefits from the Medicare prescription drug plan or a print-out from the pharmacy.**

Section 6 – Patient Attestation and Signature (required)

Patient signature is required for eligibility determination.



Patient Assistance Program for Medicare Beneficiaries

Mail to: Boehringer Ingelheim CARES Foundation, Inc.
PO Box 66745
St. Louis, MO 63166-6745
Telephone 1-800-556-8317
Hours of Operation: Monday – Friday 7:30 am – 5:30 pm CST
Fax: 1-866-727-5891

Section 1 - Physician and Prescription Information

Physician Name, DEA or State License #, Phone, Address, City, State, Zip

Prescription

Product Name/Strength, Quantity

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance other than Medicare Part D for this prescription.

Physician Signature, Date

Section 2 - Patient Information

Patient Name, SS#, Street Address, Date of Birth, Male/Female, City, State, Zip, Phone, Number of Household members, U.S. Resident?, Are you a Veteran of the US Armed Forces?, Are you Disabled?

Section 3 - Financial Information

Note: You must attach copy of your most recent federal Income Tax Return, i.e., IRS Form 1040, 1040A, 1040EZ, 1099

List All Sources, Gross Monthly Amounts

Salary/Wages, Social Security, Child Support/Alimony, Disability, Pension/Retirement, Unemployment/Work Comp

Total Gross Household Monthly Income: \$

Section 4 - Social Security Low Income Subsidy (LIS) Note: A LIS Denial letter must be attached.

- 1. Are you eligible for Low Income Subsidy for Medicare Part D?
2. Have you received a denial letter from the Low Income Subsidy?
3. If you received a denial from Low Income Subsidy by phone or do not have a copy of your denial letter, please initial the following statement:

I confirm that I have received a denial (verbal or written) from the Medicare Part D Low Income Subsidy. initial here.

Section 5 - Prescription Drug Information

Private Drug Coverage, Medicaid, Medicare, Medicare Part D

Total Amount Spent on Prescription Medications Since January 1 (required): \$

Note: In order to be eligible, a patient must have spent at least 3% of their annual household income on prescriptions during the current calendar year.

Section 6 - Patient Attestation and Signature (required)

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application...

Patient's Signature, Date