Boehringer Ingelheim

CARES FOUNDATION
...improving lives through philanthropy

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

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.

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Patient Assistance Program for Medicare Beneficiaries

Section 1 - Physician and Prescription Information

Physician Name	DEA or State License #:	Phone: ( ) Fax: ( )	
Address:	City:	State:	Zip:

Prescription

Product Name/Strength	**Quantity**
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. Patients on Medicaid and other public assistance programs are ineligible. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party, including Medicare Part D.

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 (including self)? (circle one) 1 2 3 4 5 6 7 greater than 7	U.S. Resident? Yes ☐ No ☐	Are you a Veteran of the US Armed Forces? Yes ☐ No ☐	Are you Disabled? Yes ☐ No ☐

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?** ☐ Yes ☐ No ☐ Unsure ☐ Application Pending
2. **Have you received a denial letter from the Low Income Subsidy?** ☐ Yes ☐ No **If yes, please attach a copy with your application.**
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
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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. You must 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)

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, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize the Boehringer Ingelheim CARES Foundation, Inc. to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application although Boehringer Ingelheim Cares Foundation, Inc. is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking.

Patient's Signature:	Date: