NEW YORK STATE | EPIC Elderly Pharmaceutical Insurance Coverage Program

and Medicare Working Together

Reset Form

Application

Please print clearly!

Who is applying? ☐ Yourself **only** ☐ Yourself **and your spouse**

Your Last Name | First | Middle Initial

c/o Name (if different from above)

Address Where You Live (not P.O. Box)

City | State | ZIP

Address Where You Get Your Mail (if different from above)

City | State | ZIP

Social Security Number

___ ___ ____

Sex

☐ Female ☐ Male

Your Date of Birth

Month / Day / Year

Your Telephone Number

Area Code Number

( )

Marital Status

☐ Widowed, Single or Divorced

☐ Married

☐ Married, Living Separately

Spouse's Name (If Living)

Last Name | First | Middle Initial

Spouse's Social Security Number

___ ___ ____

Spouse's Date of Birth

Month / Day / Year

Enter your Medicare Claim Number (red, white and blue card) _____

Enter your Spouse's Medicare Claim Number (red, white and blue card) _____

(Please fill in page 2)

NEED HELP? CALL TOLL-FREE: 1-800-332-3742
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Report your total income for the previous calendar year.

- **If you are married, and living together, you must report the combined yearly income for you and your spouse even if only one of you is applying. If married but living apart, report only your yearly income.**
- **Multiply monthly amounts by 12 to get yearly income.**

	Your Yearly Income	Spouse's Yearly Income
1. Social Security and/or Railroad Retirement Benefits, (less Medicare Part B premiums) paid to you by check or direct deposit.	$ _____	$ _____
2. Other Income: Include Pensions, Annuities, Interest, Dividends, IRA Distributions, Capital Gains, Wages, Business Income or Losses, Net Rental Income, etc.	$ _____	$ _____
3. TOTAL YEARLY INCOME (Add lines **1** and **2**)	$ 0	$ 0

Read carefully and sign below:

I certify that the information on this form is correct. I reside in New York State and am not currently receiving full Medicaid benefits. I know that I am required to give proof of my age, income, residency, Medicare status and Medicare Part D drug plan, if any. I also know that I am required to enroll in a Medicare Part D drug plan in order to be enrolled in EPIC. I understand that failure to provide identifying information necessary to enroll in a Part D plan, or the Medicare subsidy (Extra Help), if eligible, may result in termination of EPIC coverage. I consent to the exchange of all information necessary to verify my eligibility among and between EPIC, the Social Security Administration, Medicare, the NYS Medicaid Program, the NYS Tax Department, Medicare Part D drug plans, and any other necessary entities. In the event of duplicate or overpayment by EPIC, I assign to EPIC any drug benefits that I may be entitled to under any Part D or governmental plan. I authorize my health care providers to release to the EPIC program my medical information pertaining to prescriptions and/or diagnosis to be used for payment, audit or related health care operations.

You (and your spouse if living together) must sign below:

_____ _____

Your signature (legal representation) Date

_____ _____

Spouse's signature (legal representation) Date

Authorization (OPTIONAL): I agree that EPIC can disclose my information to the following persons/family members who are involved in my health care as necessary to process my EPIC benefits.

_____

Please print names

Mail this completed form to: **EPIC**
P.O. Box 15018
Albany, NY 12212-5018

or Fax: (518) 452-3576

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The information on this application is kept strictly confidential and is used only to determine your eligibility for EPIC.