



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

DIVISION OF ELDERLY AFFAIRS

Please complete all of the green squares below if you wish to apply for RIPAE claim/s reimbursement while in the coverage gap ("donut hole"):

Name: [] Social Security # []

Street Address: [] City/Town/Zip Code []

Telephone: [] Medicare Number (from your red, white, and blue card): []

E-mail address (if you have one): [] Date of Birth [] Number of Daily Medications: []

RIPAE Member ID Number: [] Number of Generic Drugs: []

RIPAE Group ID Number: [] Number of Brand Drugs: []

Is approved documentation attached? Circle Yes or No [YES or NO]

Medicare Part D Plan Name: []

Medicare Part D Plan ID Number: []

Disclaimer: I hereby file this claim with the Department of Human Services, Division of Elderly Affairs for claim/s reimbursement under the Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) program. I understand that the information contained in this application, along with my Medicare Part D information, will be used in the determination of my eligibility for this reimbursement. I know that the information I have provided is confidential. The Division will use this information only for purposes directly related to the RIPAE program and its administration, and will not release information about me or other members of my household without my consent, except as provide by federal and/or state law. Any person violating the provisions of Chapter 42-66.2 of the Rhode Island General Laws, as amended, may be subject to imprisonment for a term of not more than one (1) year or a fine of not less than five hundred dollars (\$500), or both. I know that my eligibility will not be affected by my race, color, national origin, disability, sex, age, religion, or sexual orientation except where it is restricted by state law.

If found ineligible for these benefits, I may re-apply at any time. I know that I have a right to appeal and receive a hearing before a Department/Division hearing officer if I am dissatisfied with any Division decision or if the Division delays in making a decision on my application. I have read and understand all of these rights and responsibilities. I certify under penalty of perjury that my responses are accurate and complete to the best of my knowledge and belief.

Applicant's Signature _____ Date: _____

Approved: _____ Signature of Reviewer _____ Signature of Supervisor _____