



Medicare

Application for Medicare Part B Immunosuppressive Drug Coverage

If you only have Medicare because of End-Stage Renal Disease (ESRD), use this form to sign up for Medicare Part B Immunosuppressive Drug Coverage (Part B-ID) if you lost (or will be losing) your Medicare coverage after a kidney transplant.

- Part B-ID helps pay for immunosuppressive drugs beyond 36 months after a kidney transplant.
- You can only apply for Part B-ID if you don't have certain types of other health coverage (like a group health plan, TRICARE, or Medicaid that covers immunosuppressive drugs).
- Part B-ID only covers immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage.
- You'll pay a monthly premium and an annual deductible for Part B-ID.

Get more information about Part B-ID at [Medicare.gov/basics/end-stage-renal-disease](https://www.Medicare.gov/basics/end-stage-renal-disease).

When can you sign up for Part B-ID?

You can sign up for Part B-ID anytime.

If you enroll in Part B-ID **before** your Medicare coverage ends, your Part B-ID coverage starts the month after Medicare ends. If you enroll in Part B-ID **after** your Medicare ends, Part B-ID will start the month after you enroll.

Submit this form by mail

Mail your completed, signed form to:

Social Security Administration
Office of Central Operations
PO Box 32914
Baltimore, Maryland 21298

You can also apply for Part B-ID by calling 1-877-465-0355. TTY users can call 1-800-325-0778.

Get help with this form

- **Phone:** Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.
- **En Español:** Llame a SSA gratis al 1-800-772-1213 y oprima el 2 si desea el servicio en español y espere a que le atienda un agente.
- **In person:** Visit your local Social Security office for in-person help. Find an office near you at [SSA.gov/locator](https://www.SSA.gov/locator).
- **State Health Insurance Assistance Program (SHIP):** Visit [shiphelp.org](https://www.shiphelp.org) to get free, personalized, and unbiased health insurance counseling from your local SHIP.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.Medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Application for Medicare Part B Immunosuppressive Drug Coverage

Social Security Number (SSN) or Medicare Number, if you have one

SSN: [][][]-[][]-[][][][] Or, Medicare Number: [][][][]-[][][]-[][][][]

First name

Middle name

Last name

Suffix

Home address (leave blank if you don't have one)

City

State

ZIP code

Mailing address (if different from home address)

City

State

ZIP code

Phone number

([][][]) [][][]-[][][][]

Email address (optional)

☐ I authorize Social Security and Medicare to send me emails about my benefits and coverage.

I attest that:

☐ I don't have any of the following coverage:

- Employer Group Health Plan or Individual Health Plan (defined in section 2791 of the Public Health Service Act)
- TRICARE for Life (established at 10 USC 1086(d))
- Medicaid (Title XIX of the Social Security Act) or State Children's Health Insurance Program (CHIP) (Title XXI of the Social Security Act) if such coverage includes immunosuppressive drugs
- Enrolled in the patient enrollment system of the Department of Veterans Affairs (VA) (38 USC 1705) or otherwise eligible to receive immunosuppressive drugs from the VA

☐ If I enroll in any of these excluded health coverages I'll notify Social Security within 60 days of obtaining that coverage

☐ I understand that anyone who makes a false statement to enroll in a health care benefit program may be fined or imprisoned or both¹

Signature

Date signed (mm/dd/yyyy)

[][]/[][]/[][][][]

If this form has been signed by mark (X), a witness who knows the person applying must also sign below:

Name of witness (first and last name)

Signature of witness

Date signed (mm/dd/yyyy)

[][]/[][]/[][][][]

¹ 18 U.S. Code § 1035 - False statements relating to health care matters:

a. Whoever, in any matter involving a health care benefit program, knowingly and willfully—

1. falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
2. makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

b. As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

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Privacy Act Statement: Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you're entitled to Part B. While you don't have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment.

Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS and in accordance with System of Records Notice (SORN) "HHS/ CMS/CBC Enrollment Database", System No. 09-70-0502, 73 Federal Register 10249, February 26th, 2008 and as permitted by the Privacy Act of 1974, to 1) Determine your rights to Social Security benefits and/or Medicare coverage. 2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration) 3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1428. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Social Security Administration at 1-800-772-1213. TTY users can call 1-800-325-0778.