CARDHOLDER ENROLLMENT APPLICATION

This application is for initial and renewal enrollment in the Chronic Renal Disease Program (CRDP).

You are eligible to participate in the Chronic Renal Disease Program if:

- YOU HAVE END-STAGE RENAL DISEASE AND ARE CURRENTLY RECEIVING DIALYSIS OR HAVE HAD A KIDNEY TRANSPLANT; AND
- YOU HAVE LIVED IN PENNSYLVANIA FOR AT LEAST 90 DAYS PRIOR TO THE DATE OF YOUR APPLICATION OR YOU CAN SHOW AN INTENT TO MAINTAIN A PERMANENT HOME IN PENNSYLVANIA FOR THE INDEFINITE FUTURE; AND
- YOU ARE A U.S. CITIZEN OR LEGAL ALIEN; AND
- YOUR INCOME IS WITHIN GUIDELINES SPECIFIED BY THE PENNSYLVANIA DEPARTMENT OF HEALTH.

ELIGIBILITY REQUIREMENTS:

Supporting documents MUST be submitted with the application to avoid delay in processing. Please do not send originals – 8 ½" x 11" photocopies are preferred.

- **Proof of Citizenship (first-time applicants only)**
  Please submit one of the following documents:
  - Birth certificate;
  - Naturalization papers;
  - Pa. Department of Human Services Medical Assistance ID card;
  - U.S. passport;
  - Voter registration card;
  - Military ID card;
  - Immigration and Naturalization Service employment card; or
  - Any document from the Social Security Administration (SSA) showing name and SSN. (Social Security card is NOT acceptable for proof of citizenship.)

- **Proof of Social Security Number (first-time applicants only)**
  Please submit one of the following documents:
  - Social Security card;
  - SSA1099 or SSA-100 statement; or
  - W-2 statement.

- **Proof of Residency (documents cannot be more than two years old)**
  Please submit one of the following documents:
  - Pa. Driver's license, vehicle owner's card or State issued ID;
  - Pre-printed rent receipts or utility receipts;
  - Unemployment Compensation card;
  - Dated Social Security correspondence; or
  - Letter from a long-term care facility signed/dated by the director or administrator, stating admission date.
  - Voter Registration card

- **Proof of Income (all sources of income)**
  Please do one of the following:
  - If you filed a Federal 1040 for the prior calendar year, you must submit a copy of the tax form with your application.
  - If you did not file a Federal 1040 tax form for the prior calendar year, you must submit appropriate documents to support the prior calendar year income indicated on the application:
    - RRB-1099/RRB-1099R (Railroad Board);
    - 1099 (Social Security, pension, annuities, IRAs, business Income);
    - Official document from the Pension Fund administrator verifying pension amount;
    - Financial statement verifying interest earned;
    - W-2 form; or
    - Notarized letter providing specific information to verify amount and source of income earned, address, and phone number of the payer.

- **INSURANCE AND HEALTH CARE COVERAGE:**
  All insurance ID cards and effective dates (when coverage began) must be included with the application. If your insurance card does not show an effective date you can provide ONE of the following alternative documents as proof of policy effective date for each health coverage program:
  - A letter from your insurance carrier which shows the effective date of coverage;
  - A screenshot from a personal online insurance portal; or
  - A copy of screenshot from a billing system or insurance verification system.

pennsylvania
DEPARTMENT OF HEALTH

CARDHOLDER APPLICATION

CHRONIC RENAL DISEASE PROGRAM
ELIGIBILITY UNIT
P.O. BOX 8811
HARRISBURG, PA 17105-8811

1 Applicant Information

Use black or blue ink only.

CRDP ID # (if known)_____ **Social Security number**_____

Last name_____ First name_____ Middle initial_____

Home address_____ Apt. #_____

City_____ State_____ Zip_____

Home phone (_____)_____

Date of birth _____/_____/_____ (MM / DD / YYYY) Citizenship status: ☐ U.S. Citizen ☐ Legal alien

Mailing address if you use a Pennsylvania PO Box:

P.O. Box_____ City_____ State_____ Zip_____

RACE (Optional) Circle one:

1 American Indian/Alaskan Native
2 Asian/Pacific Islander
3 Black/African American
4 White
5 Multiracial/other
6 Unknown

ETHNICITY (Optional) Circle one:

1 Hispanic Origin
2 Not of Hispanic Origin

GENDER (Circle one)

1 Male
2 Female
3 Transgender
4 Self-describe

MARITAL STATUS (Circle one):

1 Single/widowed
2 Married
3 Divorced since (year)_____
4 Married/living separately since (year)_____

SPOUSE'S INFORMATION (if applicable):

Spouse's name_____

Spouse's SSN_____

2 Income – Documents must be submitted to support all income checked (see page 2).

Number of additional dependents (do not include yourself or your spouse): _____

☐ YES ☐ NO Did you file a federal 1040 income tax return for the prior calendar year?

☐ YES ☐ NO Did anyone else claim you as a dependent on a 1040 for the prior calendar year?

Check all boxes for income earned in the prior calendar year for you (and your spouse/dependents if applicable).		Self	Spouse	Deps.
1	Social Security – include Medicare premiums and Supplemental Security Income (SSI)			
2	Railroad Retirement Benefits (RRB-1099 and RRB-1099R forms)			
3A	SERS (State Employees Retirement) pension -- (Retired State Employees)			
3B	PSERS (Public School Employees Retirement) pension - (Retired Public School Employees)			
4	Gross pensions (not listed in 3A or 3B above) and taxable amount of all annuities and IRAs			
5	Interest, dividends, capital gains			
6	Wages, bonuses, commissions, self-employment, partnerships, net rental, net business, cash public assistance, unemployment, Workers' Comp., alimony, gambling, prizes, royalties, gifts and inheritance over $300, death benefits over $5000			

Name_____ **Social Security number:** _____

3 Other Insurance and Health Care Coverage – All ID cards must be submitted.

All insurance ID cards and effective dates (when coverage began) must be included with the application.

Do you currently have any other insurance or health care coverage?

☐ Yes – Complete the insured section below and provide a copy of your insurance card(s) and effective dates of coverage.

☐ No – I do not have other insurance or health care coverage.

Medicare Claim Number: _____

___ **Medicare Part A** Effective date: _____

___ **Medicare Part B** Effective date: _____

___ **Medicare Advantage** Effective date: _____

___ **Medicare Part D** Effective date: _____

___ **Medicaid/Medical Assistance** Effective date: _____

___ **U.S. Veterans Administration** Effective date: _____

___ **Other (Write plan name[s] and effective date[s] below.)**

Other plan name_____ Effective date: _____

Other plan name_____ Effective date: _____

4 Signature and Date

By signing, I acknowledge that I have read the Certification and Authorization Statements on the back of this application and agree to the terms stated, and that I have lived in Pennsylvania for at least 90 days or intend to maintain a permanent home in Pennsylvania, and that all information supplied herein is true, correct and complete.

Applicant signature (must be signed or marked with an X)

_____ **Date**_____

Power of attorney or court-appointed guardian may sign for applicant. (Proof is required.)	**Witness/preparer's signature** (If applicant's signature is marked with an X)
_____	_____

THIS PHYSICIAN'S STATEMENT MUST BE RETURNED WITH YOUR APPLICATION

CRDP ID # RX_____ Patient's name (Please print.): _____

Patient's Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

CONFIDENTIAL **Application for Services**

THIS SECTION MUST BE COMPLETED, SIGNED, AND DATED BY THE PATIENT'S ATTENDING PHYSICIAN.

INDICATE BELOW THE APPROPRIATE ICD-10-CM CODE AND DESCRIPTION FOR THE PRIMARY CAUSE OF END-STAGE RENAL DISEASE. USE THE LIST OF ACCEPTABLE ICD-10-CODES PROVIDED IN THE APPLICATION PACKET.

ICD-10-CM CODE

☐☐☐.☐☐☐☐ _____

PLEASE LIST ANY APPROPRIATE SECONDARY ICD-10-CM CODE AND DESCRIPTIONS:

ICD-10-CM CODE

☐☐☐.☐☐☐☐ _____

CHECK THE TYPE OF SERVICE RENDERED TO THE PATIENT:
(check one only - if transplant recipient and not receiving dialysis do not complete dialysis information)

☐ DIALYSIS ☐ TRANSPLANT
Date of Transplant: _____
MM DD YYYY

IF ON DIALYSIS, CHECK PLACE OF TREATMENT:

☐ DIALYSIS CENTER
☐ HOME DIALYSIS

IF ON DIALYSIS, CHECK TYPE OF DIALYSIS:

☐ HEMODIALYSIS ☐ CAPD
☐ CCPD ☐ OTHER_____

DATE OF FIRST DIALYSIS TREATMENT: _____/_____/_____
MM DD YYYY

NUMBER OF TREATMENTS PER WEEK: ____

IF TRANSPLANT FAILED, ENTER THE DATE DIALYSIS WAS REINSTATED: _____/_____/_____
MM DD YYYY

I certify that the narrative description(s) of the patient's diagnosis (es) are complete, as written, and accurate to the best of my knowledge; and I have obtained appropriate written consent for the disclosure of this medical information, including written consent for the disclosure of any HIV-related information as set forth in Section 7606 of the Confidentiality of HIV-Related Information Act, 35 P.S. Section 7601 et. Seq.

I CERTIFY THAT THIS PATIENT IS IN END-STAGE RENAL DISEASE, ICD-10-CM CODE N18.6, OR HAD A KIDNEY TRANSPLANT, OR ICD-10-CM CODE Z94.0.

_____ _____
Physician's signature (APRN, CRNP, OR PA SIGNATURE IS ALSO ACCEPTABLE) **Date: MM DD YYYY**

Physician's name (last, first) _____

Physician's NPI number

☐☐☐☐☐☐☐☐☐☐

Facility or medical practice NPI number

☐☐☐☐☐☐☐☐☐☐

Dialysis/transplant/treating physician facility name _____

Address _____

_____
City **State** **Zip code + Four**

Phone # (**)** _____

Social worker/transplant coordinator/treating physician office email: _____

CHRONIC RENAL DISEASE PROGRAM
LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE

Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10 CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary.

ICD-10	Description

DIABETES

E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease

E10.29 Type 1 diabetes mellitus with other diabetic kidney complication

E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease

E11.29 Type 2 diabetes mellitus with other diabetic kidney complication

GLOMERULONEPHRITIS

N00.8 Acute nephritic syndrome with other morphologic changes

N01.9 Rapidly progressive nephritic syndrome with unspecified morphologic changes

N02.8 Recurrent and persistent hematuria with other morphologic changes

N03.0 Chronic nephritic syndrome with minor glomerular abnormality

N03.1 Chronic nephritic syndrome with focal and segmental glomerular lesions

N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis

N03.3 Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis

N03.4 Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis

N03.5 Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis

N03.6 Chronic nephritic syndrome with dense deposit disease

N03.7 Chronic nephritic syndrome with diffuse crescentic glomerulonephritis

N03.8 Chronic nephritic syndrome with other morphologic changes

N03.9 Chronic nephritic syndrome with unspecified morphologic changes

N04.0 Nephrotic syndrome with minor glomerular abnormality

N04.1 Nephrotic syndrome with focal and segmental glomerular lesions

N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis

ICD-10	Description

TRANSPLANT COMPLICATIONS

T86.00 Unspecified complication of bone marrow transplant

T86.10 Unspecified complication of kidney transplant

T86.20 Unspecified complication of heart transplant

T86.40 Unspecified complication of liver transplant

T86.819 Unspecified complication of lung transplant

T86.859 Unspecified complication of intestine transplant

T86.899 Unspecified complication of other transplanted tissue

HYPERTENSION/ LARGE VESSEL DISEASE

I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

I15.0 Renovascular hypertension

I15.8 Other secondary hypertension

I75.81 Atheroembolism of kidney

CYSTIC/ HEREDITARY/ CONGENITAL/ OTHER DISEASES

E72.04 Cystinosis

E72.53 Hyperoxaluria

E75.21 Fabry (-Anderson) disease

N07.8 Hereditary nephropathy, not elsewhere classified with other morphologic lesions

N31.9 Neuromuscular dysfunction of bladder, unspecified

Q56.0 Hermaphroditism, not elsewhere classified

Q60.2 Renal agenesis, unspecified

Q61.19 Other polycystic kidney, infantile type

Q61.2 Polycystic kidney, adult type

Q61.4 Renal dysplasia

Q61.5 Medullary cystic kidney

Q61.8 Other cystic kidney diseases

Q62.11 Congenital occlusion of ureteropelvic junction

Q62.12 Congenital occlusion of ureterovesical orifice

Q63.8 Other specified congenital malformations of kidney

Q64.2 Congenital posterior urethral valves

Q79.4 Prune belly syndrome

Q85.1 Tuberous sclerosis

Q86.8 Other congenital malformation syndromes due to known exogenous causes

Q87.1 Congenital malformation syndromes predominantly associated with short stature

ICD-10	Description
Q87.81	Alport syndrome
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis
N04.6	Nephrotic syndrome with dense deposit disease
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis
N04.8	Nephrotic syndrome with other morphologic changes
N04.9	Nephrotic syndrome with unspecified morphologic changes
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality
SECONDARY GLOMERULONEPHRITIS / VASCULITIS	
D59.3	Hemolytic-uremic syndrome
D69.0	Allergic purpura
I77.89	Other specified disorders of arteries and arterioles
M31.0	Hypersensitivity angiitis
M31.1	Thrombotic microangiopathy
M31.31	Wegener's granulomatosis with renal involvement
M31.7	Microscopic polyangiitis
M32.0	Drug-induced systemic lupus erythematosus
M32.10	Systemic lupus erythematosus, organ or system involvement unspecified
M32.14	Glomerular disease in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M34.89	Other systemic sclerosis
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS	
N10	Acute tubulo-interstitial nephritis
N11.9	Chronic tubulo-interstitial nephritis, unspecified
N13.70	Vesicoureteral-reflux, unspecified
N13.8	Other obstructive and reflux uropathy
NEOPLASMS/ TUMORS	
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C80.1	Malignant (primary) neoplasm, unspecified
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C88.2	Heavy chain disease
C90.00	Multiple myeloma not having achieved remission
D30.9	Benign neoplasm of urinary organ, unspecified
D41.00	Neoplasm of uncertain behavior of unspecified kidney
D41.9	Neoplasm of uncertain behavior of unspecified urinary organ
E85.9	Amyloidosis, unspecified
N05.8	Unspecified nephritic syndrome with other morphologic changes
DISORDERS OF MINERAL METABOLISM	
E83.52	Hypercalcemia
GENITOURINARY SYSTEM	
A18.10	Tuberculosis of genitourinary system, unspecified
N28.9	Disorder of kidney and ureter, unspecified
ACUTE KIDNEY FAILURE	
N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.9	Acute kidney failure, unspecified
MISCELLANEOUS CONDITIONS	
B20	Human immunodeficiency virus [HIV] disease
D57.1	Sickle-cell disease without crisis
D57.3	Sickle cell trait
I50.9	Heart failure, unspecified
K76.7	Hepatorenal syndrome
M10.30	Gout due to renal impairment, unspecified site
N14.0	Analgesic nephropathy
N14.1	Nephropathy induced by other drugs, medicaments and biological substances
N14.3	Nephropathy induced by heavy metals
N20.0	Calculus of kidney
N25.89	Other disorders resulting from impaired renal tubular function
N26.9	Renal sclerosis, unspecified
N28.0	Ischemia and infarction of kidney
N28.89	Other specified disorders of kidney and ureter
O90.4	Postpartum acute kidney failure
S37.009A	Unspecified injury of unspecified kidney, initial encounter
Z90.5	Acquired Absence of Kidney

CERTIFICATION AND AUTHORIZATION STATEMENTS

I understand that my signature on the Chronic Renal Disease Program (CRDP) application indicates my agreement to the following provisions:

A. I authorize the Internal Revenue Service, the Social Security Administration, the U.S. Railroad Retirement Board, the Pa. Dept. of Revenue, the Pa. Dept. of Transportation, the Public School Employees' Retirement System, the State Employees' Retirement System, any other federal or state agency and any other financial or other institution or entity with information on my income or resources to release information to the Dept. of Health that will verify my eligibility for the CRDP or for the low income subsidy of the federal Medicare prescription drug benefit. All information released to the Department of Health shall remain confidential in accordance with 72 P.S. §3761-517(b).

B. I authorize the Department of Health (Department) or its authorized representative to visit my residence with reasonable prior notice to me, for the purpose of determining the validity of information provided on the application or any claims made under CRDP.

C. I understand that the Department of Health or its authorized representative, within its discretion, may disclose any and all medical information in my CRDP file with the exception of any HIV-related information, to business partners, contractors, grantees and other public health programs for the legitimate business purposes of the CRDP. I agree to authorize such disclosure of information, if a further written authorization is required, by executing an appropriate authorization form.

D. I hereby assign to the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to benefits to which I may be entitled under any other plan of government assistance or insurance from any third party payor. I hereby designate the Commonwealth of Pennsylvania's CRDP, acting through its contractors and agents, as my agent and authorized representative for the limited purpose of applying for such government assistance or insurance. I understand that I may decline the choice of third party payor that may be made by CRDP on my behalf by indicating my preference of appropriate third party payor to CRDP in writing.

E. I hereby waive the confidentiality of any health care information found in any Medicare HMO, third party payor's file or any other health care source, except for HIV-related information; I authorize disclosure of this information to the CRDP, its contractors and agents. If the holders of this information require further signed authorizations in order to disclose information about me, I agree that I will cooperate with the Department and promptly execute the appropriate authorizations.

F. I agree that I will not receive payment, or authorize the receipt of payment on my behalf, from the Department of Health for any amount which has been paid by any other plan of government assistance or insurance or any other third party payor on my behalf.

G. I understand that if it is determined that CRDP benefits have been paid improperly, I shall be required to repay such benefits. I authorize such collections from myself, my estate, my agents and my personal representatives.

H. I understand that any person who submits a false or fraudulent claim or application under CRDP, or who aids and abets another in the submission of a false or fraudulent claim or application, or who claims and receives duplicate benefits may be charged with a criminal offense, including an offense under 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities. Any person who is found guilty of such a criminal offense shall be subject to repay CRDP in full for previous services.

I. I understand that the Department allows an appeal in the event I disagree with any decision made by the CRDP regarding my eligibility or benefits. I may appeal a decision by filing a CRDP appeal form according to its instructions.

J. I authorize the Department of Health or its designee to act as my representative for determining my eligibility and applying for the low income subsidy of the Medicare prescription drug benefit, enrolling me in the Medicare prescription drug plan that best fits my prescription needs, handling any and all aspects of Part D on my behalf consistent with federal law, and paying the premium of selected Medicare prescription drug plans that are less than or equal to the regional benchmark premiums.

K. I understand CRDP may refer me to another agency to obtain health care benefits (example: Medicare, Medical Assistance) if appropriate, and that my eligibility for CRDP may be contingent upon my application for and acceptance of other appropriate health care benefits or insurance programs.

NON-CREDITABLE COVERAGE

Since the CRDP offers a limited formulary, the prescription coverage received from CRDP is not equivalent to the prescription benefits offered by Medicare Part D, which means CRDP is considered “non-creditable.” This means it may be in your best interest to be enrolled in CRDP and a Medicare Part D plan together.
When you become eligible for Medicare, if you do not have any prescription coverage that is considered creditable, you should enroll in a Medicare Part D plan. Otherwise, you may pay a higher premium to join a Medicare drug plan. If you go 63 days or longer without prescription drug benefits that are at least as good as the coverage offered through the Medicare benefit, you will have to pay a 1 percent penalty on the monthly Part D premium for every month you go without coverage.
After you are enrolled in CRDP, the program can assist you in enrolling in a Part D plan when you become Medicare eligible or during the Part D annual enrollment period.

AUTHORIZED SIGNATURE

The Department of Health shall accept the attorney-in-fact or court-appointed guardian as an authorized agent for the purpose of enrollment. Power of attorney or guardianship documentation must be provided.

Checklist

Have you:

- ☐ **Filled out the application completely in black or blue ink?**
- ☐ **Signed and dated the application?**
- ☐ **Included copies of all required documentation (citizenship, residency, and all sources of prior year income)?**
- ☐ **Included power of attorney or court-appointed guardianship (if needed)?**
- ☐ **Included the completed Physician’s Statement?**
- ☐ **Included copies of all insurance and health coverage ID cards (including Medicare and Medical Assistance)?**

Use the enclosed envelope to mail your application and required documents to:

Pennsylvania Department of Health
Eligibility Unit
P.O. Box 8811
Harrisburg, PA 17105-8811

NEED ASSISTANCE WITH THIS APPLICATION OR HAVE QUESTIONS REGARDING ELIGIBILITY?

CALL
TOLL-FREE
1-800-225-7223

HEARING IMPAIRED NUMBER
1-800-222-9004
(Only calls from hearing impaired individuals will be accepted at this number.)

APPLICATIONS MAY BE FAXED OR EMAILED:

FAX NUMBER
1-888-656-0372

E-Mail
PAPACE@MAGELLANHEALTH.COM

COLLECT CALLS WILL NOT BE ACCEPTED.