

**PENNSYLVANIA DEPARTMENT OF HEALTH
CHRONIC RENAL DISEASE PROGRAM
CHANGE OF PATIENT STATUS**

Complete this form for all changes that affect a patient's eligibility for or receipt of program services. Such services may include dialysis, hospitalization, transplant, physician care and ancillary services including laboratory, x-ray and pharmaceutical services. Print the name and Social Security Number in the space indicated; place a (x) by the data being updated; and, print the new information in each application section.

Mail to: Pennsylvania Department of Health
Chronic Renal Disease Program Eligibility Unit
P.O. Box 8811
Harrisburg, PA 17105-8811

Phone Number: 1-800-225-7223
CRDP Fax Number: (888) 656-0372

CRDP CPSF 03/13

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|--|---|---|
| Patient: _____ | | CRDP ID Number: RX _____ |
| DOB: ____/____/____ | | Social Security #: _____ |
| (X) | ITEM TO BE CHANGED | NEW INFORMATION |
| | ADDRESS | HOME ADDRESS: _____ APT #: ____ CITY: _____ STATE: ____ ZIP CODE: _____ TELEPHONE: _____ EFFECTIVE DATE: ____/____/____ |
| | DIALYSIS <input type="checkbox"/> CENTER <input type="checkbox"/> TREATMENT | CENTER NAME: _____ PROVIDER ID# 39- _____ <input type="checkbox"/> FIRST DATE OF DIALYSIS AT NEW CENTER : DATE BEGAN: ____/____/____ <input type="checkbox"/> HOME DIALYSIS <input type="checkbox"/> IN CENTER <input type="checkbox"/> TREATMENTS PER WEEK # _____ DATE WITHDRAWN FROM THIS CENTER ____/____/____ DID PATIENT ENTER A NEW CENTER? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | TRANSPLANT | DATE OF TRANSPLANT: ____/____/____ DATE RETURN TO DIALYSIS: ____/____/____ DATE OF REJECTION: ____/____/____ INSTITUTION NAME & ADDRESS: _____ |
| | MEDICARE A, B, C, D OR PRIVATE INSURANCE INFORMATION <input type="checkbox"/> CHANGE <input type="checkbox"/> PRIMARY <input type="checkbox"/> ADD <input type="checkbox"/> SECONDARY <input type="checkbox"/> DELETE <input type="checkbox"/> MED PART D | POLICYHOLDER: _____ COMPANY: _____ EFFECTIVE DATE: ____/____/____ END DATE: ____/____/____ TYPE OF COVERAGE: Basic Medical Major Medical Managed Care (CIRCLE TYPE) Prescription Medicare Part A Medicare Part B MEDICARE CLAIM NUMBER: _____ |
| ATTACH COPY OF INSURANCE CARD (S) | | |
| | FINANCIAL STATUS | ATTACH APPROPRIATE INCOME DOCUMENTATION TO SUBSTANTIATE THE CHANGE AND THE REASON FOR THE CHANGE. DOCUMENTATION MAY INCLUDE, BUT IS NOT LIMITED TO, LETTERS FROM EMPLOYER, DISABILITY, DEPARTMENT OF PUBLIC ASSISTANCE, ETC. |
| | DEATH | DATE OF DEATH: ____/____/____ |
| | PERSON COMPLETING THIS REPORT | NAME: _____ PHONE#: _____ ADDRESS: _____ PROVIDER ID# 39- _____ _____ _____ SIGNATURE: _____ DATE: _____ |