

# CARDHOLDER RENEWAL APPLICATION

This Application is for re-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 CONTINUE TO REQUIRE SERVICES; AND
- YOU STILL LIVE IN PENNSYLVANIA OR CAN SHOW AN INTENT TO MAINTAIN A PERMANENT HOME IN PENNSYLVANIA FOR THE INDEFINITE FUTURE; AND
- YOU ARE STILL A U.S. CITIZEN OR LEGAL ALIEN; AND
- YOUR INCOME IS WITHIN GUIDELINES SPECIFIED BY THE PENNSYLVANIA DEPARTMENT OF HEALTH.



# CRDP ELIGIBILITY REQUIREMENTS

## ANNUAL INCOME (*proof required*)

### DOCUMENTATION FOR PROOF OF INCOME

If you completed a Federal 1040 Tax Form, you must attach a photocopy of your prior calendar year tax form to your application. The 1040 Tax Form is the document you must use to support the income listed on your application.

If you receive Social Security benefits, you must also submit a photocopy of your prior calendar year SSA-1099.

If you did not complete a Federal Tax Form, you must read the following and attach the appropriate documents required to support the income.

Photocopies of the following documents are acceptable as proof of income:

- **LINE 1: TOTAL PRIOR CALENDAR YEAR GROSS SOCIAL SECURITY. INCLUDE MEDICARE PREMIUMS AND SUPPLEMENTAL SECURITY INCOME (SSI).**

SSA Form 1099, "Social Security Benefit Statement," or a computer printout of your Social Security benefits from SSA.

- **LINE 2: TOTAL PRIOR CALENDAR YEAR GROSS RAILROAD RETIREMENT BENEFITS (RRB-1099 AND RRB-1099R FORM).**

A photocopy of the letter from the Fund Administrator verifying prior calendar year pension and annuity income or Form RRB-1099 AND RRB-1099R, "United States Railroad Retirement Board Statement." (Both forms must be submitted.)

- **LINE 3A: TOTAL PRIOR CALENDAR YEAR SERS (STATE EMPLOYEE'S RETIREMENT) This applies to Retired State Employees Only.**
- **LINE 3B: TOTAL PRIOR CALENDAR YEAR PSERS PENSION (PUBLIC SCHOOL EMPLOYEES' RETIREMENT) This applies to Retired Public School Employees Only.**

A photocopy of the letter from the Fund Administrator verifying prior calendar year pension or 1099 form.

- **LINE 4: TOTAL PRIOR CALENDAR YEAR GROSS PENSIONS (not listed in 3A and 3B), and TAXABLE AMOUNT OF ALL ANNUITIES AND INDIVIDUAL RETIREMENT ACCOUNTS (IRAs).**

A photocopy of Form 1099 for all pensions, annuities and Individual Retirement Accounts (IRAs) must be included.

- **LINE 5: TOTAL PRIOR CALENDAR YEAR INTEREST, DIVIDENDS, CAPITAL GAINS AND PRIZES (DO NOT SUBTRACT LOSSES FROM TOTAL INCOME).**

Proceeds from the sale of your home, when used to purchase another residence for you or your spouse (must be deeded in your name or your spouse's name) or to provide long-term care for you or your spouse, is not considered income, but must be documented. (Interest earned on bank accounts established with the capital gains must be reported.)

Bank statements or similar financial statements should contain the end-of-year interest totals, name of bank and applicant name.

# CRDP ELIGIBILITY REQUIREMENTS

- **LINE 6: WAGES, SALARY, BONUSES, COMMISSIONS, SELF-EMPLOYMENT, PARTNERSHIPS, NET RENTAL, NET BUSINESS, CASH PUBLIC ASSISTANCE, UNEMPLOYMENT, WORKERS' COMP., ALIMONY, SUPPORT, GAMBLING, GIFTS AND INHERITANCE OVER \$300, AND DEATH BENEFITS OVER \$5,000.**

Photocopy of W-2 form; 1099 form; the letter from the source of income identifying the award; notarized letter providing specific information such as amount and source of income, address or phone number of source of income and applicant's name; alimony check or payment record from court.

Rent rebate forms cannot be used to document income.

## EXCLUDED INCOMES

The following types of income should **not** be included in your annual income figures:

- Black or white lung benefits
- The first \$5,000 in death benefit payments (Example: If you received a \$6,000 death benefit, only \$1,000 should be reported as income.)
- Non-cash relief, including food stamps and the 504 Loan and Grant Program from FHA
- Property tax/rent rebate payments
- The amount of damages received, whether by civil suit or settlement agreement, due to personal injuries
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Gifts totaling \$300 or less
- Refund from Income Tax

## SIGNATURE INSTRUCTIONS

**Sign and date the application.** If a signature is made with a mark (**X**), a witness must sign in the space provided. **Power of Attorney or guardianship documentation must accompany the application when signed by the Attorney-In-Fact or Court-Appointed Guardian.**

## 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% 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.

## IMPORTANT FACTS

Carefully review your income statement and make certain that you have reported all income you received during the prior calendar year. Other sources of tax information may be used by the Department of Health or its authorized representative to verify your income statement.

- To expedite the processing of your application, please:
  - **Type or print with black ink;**
  - Include the documentation as mentioned in the “CRDP Eligibility Requirements” section of this booklet; and
  - Submit all photocopies on **8½" x 11"** white paper. Be sure photocopies are one-sided and clear so they can be easily read.
- Eligible applicants must pay a copayment for each prescription.
- You may be required to meet a Patient Share of Cost (PSC) prior to receiving medical benefits. The PSC is the amount of money that you must contribute to the cost of your medical care. The amount is determined by your annual income.
- A CRDP card **cannot be forwarded to another address** in or outside Pennsylvania.
- CRDP does not provide for vacation or emergency supplies, medications or dialysis services which are rendered outside Pennsylvania. If you leave Pennsylvania, you are responsible for notifying CRDP of your departure and return dates.
- Only contracted or approved providers that are currently licensed by the Commonwealth and which have their principal place of business in this Commonwealth are eligible to participate in this program.
- Your pharmacist may dispense a 30-day supply or 100 capsules or tablets per prescription, whichever is less. Seventy-five percent (75%) of the medication must be used before the prescription can be refilled.
- CRDP reimburses up to five (5) refills on a prescription or a six (6) month supply, whichever occurs first.
- If at any time your income is found to exceed CRDP limits, your benefits will be canceled and you may be responsible for any medical care or prescription costs improperly paid on your behalf. In most cases, repayments are based on the coverage period.
- Any other medical or prescription coverage you have must be used as the primary payor. CRDP providers may not bill CRDP before billing your other third party carrier.
- If you are enrolled in a Part D plan and CRDP at the same time, the CRDP may pay your Part D monthly premium for you, cover any deductibles, and cover any copays in excess of your CRDP copay on CRDP formulary medications as long as the Part D plan has an agreement with us. For further information regarding the Part D plans, please call our toll-free cardholder services number at 1-800-225-7223.



## INSTRUCTIONS FOR COMPLETING THE CRDP RENEWAL APPLICATION

### **IMPORTANT: Must type or print with black ink.**

- A** “For Corrections Only:” Review the preprinted CRDP information and, if changes are required, make the changes in the appropriate box in Section A.
- B** “For Corrections Only:” Review the preprinted CRDP information and, if changes are required, make the changes in the appropriate box in Section B. Please provide your **spouse’s (husband/wife)** name and your **spouse’s Social Security number**. **CITIZENSHIP STATUS:** The patient must be a United States citizen or legal alien. If a correction was made, you must send a photocopy of the following documents for proof of citizenship: birth certificate, naturalization papers or INS documents.
- C** **RACE:** (Optional) Circle the number that best describes your race.  
**ETHNICITY:** (Optional) Circle the number that best describes your ethnic origin.
- D** **SEX:** Circle #1 for Male or #2 for Female.  
**MARITAL STATUS:** Circle the number which best describes your marital status. When circling #3 or #4, you must include the year.
- E** **HEALTH COVERAGE:** Complete the attached Health Coverage Information Sheet. **You must enclose photocopies of all health coverage identification cards.**
- F** **EVIDENCE OF INCOME:** 8<sup>1</sup>/<sub>2</sub>" x 11" photocopies of documents are preferred.  
All applicants must complete items 1 through 7. Please attach photocopies of your signed IRS 1040 income tax forms, including tax schedules, which will verify the income reported in this section. Attach a photocopy of all SSA-1099 forms if applicable.  
Read and answer the four questions regarding your Federal tax filing for the prior calendar year. If you checked “yes” to any of the questions, report income of all persons claimed on the Federal 1040 income tax form in the income section, lines 1 through 6.  
If you did not file an IRS 1040 income tax form, you must submit photocopies of documents to support the income you have listed on this document. If you have indicated no income on line 7, please attach an explanation of how your daily living expenses are being paid.  
Read the “**CERTIFICATION AND AUTHORIZATION**” statements on the back of the application.
- G** **SIGN AND DATE THE APPLICATION:** If the applicant’s signature is made with a mark (X), a witness or preparer must sign and provide their phone number in the space provided.
- H** **POWER OF ATTORNEY OR GUARDIAN:** “For Changes Only:” Power of Attorney or guardianship documentation must accompany the application if not previously submitted for current Power of Attorney or Guardian when signed by the Attorney-In-Fact or Court-Appointed Guardian.
- PHYSICIAN’S STATEMENT:** The physician, advanced practice registered nurse, certified registered nurse practitioner or physician’s assistant responsible for your renal treatment must complete and sign the statement.



**THIS PHYSICIAN'S STATEMENT MUST BE RETURNED WITH YOUR APPLICATION**

Patient's Name: \_\_\_\_\_

**Application for Services  
CONFIDENTIAL**

Patient's Identification Number RX: \_\_\_\_\_

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

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.

INDICATE BELOW THE APPROPRIATE ICD-10-CM CODE AND DESCRIPTION FOR THE PRIMARY CAUSE OF END-STAGE RENAL DISEASE:

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 \_\_\_\_\_

ENTER DATE OF FIRST DIALYSIS TREATMENT: \_\_\_\_\_  
MM      DD      YYYY

DATE DIALYSIS STARTED: \_\_\_\_\_  
MM      DD      YYYY

IF TRANSPLANT FAILED, ENTER DATE  
DIALYSIS REINITIATED: \_\_\_\_\_  
MM      DD      YYYY

IN CURRENT CENTER: \_\_\_\_\_  
(IF DIFFERENT THAN DATE OF FIRST DIALYSIS)

NUMBER OF TREATMENTS PER WEEK: \_\_\_\_\_

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 7607 of the Confidentiality of HIV-Related Information Act, 35 P.S. Section 7601 et. seq.

\_\_\_\_\_  
**Physician's Signature (APRN, CRNP, or PA signature also accepted)**

\_\_\_\_\_  
**Date      MM      DD      YYYY**

Physician's Name (Last, First) \_\_\_\_\_

Physician's Tax ID Number \_\_\_\_\_ (Check one) SSN \_\_\_\_\_ FID \_\_\_\_\_

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	ICD-10	Description
<b>DIABETES</b>		<b>TRANSPLANT COMPLICATIONS</b>	
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	T86.00	Unspecified complication of bone marrow transplant
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication	T86.10	Unspecified complication of kidney transplant
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	T86.20	Unspecified complication of heart transplant
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication	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
<b>GLOMERULONEPHRITIS</b>		<b>HYPERTENSION/LARGE VESSEL DISEASE</b>	
N00.8	Acute nephritic syndrome with other morphologic changes	I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes	I15.0	Renovascular hypertension
N02.8	Recurrent and persistent hematuria with other morphologic changes	I15.8	Other secondary hypertension
N03.0	Chronic nephritic syndrome with minor glomerular abnormality	I75.81	Atheroembolism of kidney
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	<b>CYSTIC/HEREDITARY/CONGENITAL/OTHER DISEASES</b>	
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis	E72.04	Cystinosis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis	E72.53	Hyperoxaluria
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis	E75.21	Fabry (-Anderson) disease
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis	N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions
N03.6	Chronic nephritic syndrome with dense deposit disease	N31.9	Neuromuscular dysfunction of bladder, unspecified
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis	Q56.0	Hermaphroditism, not elsewhere classified
N03.8	Chronic nephritic syndrome with other morphologic changes	Q60.2	Renal agenesis, unspecified
N03.9	Chronic nephritic syndrome with unspecified morphologic changes	Q61.19	Other polycystic kidney, infantile type
N04.0	Nephrotic syndrome with minor glomerular abnormality	Q61.2	Polycystic kidney, adult type
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions	Q61.4	Renal dysplasia
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis	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

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





# CHECK-OFF LIST

## HAVE YOU:

- Filled out the form completely, using black ink?
- Read the Certification and Authorization Statements?
- Signed and dated the application?
- Included a photocopy of your prior calendar year signed IRS 1040 income tax form, plus tax schedules? If you did not file an IRS 1040 for the prior calendar year, have you attached the appropriate documents to verify the income figures listed on the application?
- Included a photocopy of your prior calendar year SSA-1099 form(s), if applicable?
- Included proof of Power of Attorney or Court-Appointed Guardianship, if needed?
- Included the Physician's Statement?
- Included the Health Coverage Information Sheet?
- Included photocopies of all health coverage identification cards (inclusive of Medical Assistance and Medicare coverage cards)?

Use the enclosed envelope and 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)**

**FAX NUMBER  
1-888-656-0372**

**COLLECT CALLS WILL NOT BE ACCEPTED**

Commonwealth of Pennsylvania  
Department of Health