pennsylvania
DEPARTMENT OF HEALTH

PENNSYLVANIA DEPARTMENT OF HEALTH
CHRONIC RENAL DISEASE PROGRAM (CRDP)
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 such as laboratory, x-ray and pharmaceutical services. Print the patient name, DOB, CRDP ID Number and SS # in the spaces indicated. Place an (**x**) by the item(s) to be changed and print the new information in the space(s) provided. Changes to insurance coverage must be accompanied by a copy of the new insurance card(s) and documentation which includes the effective date of the policy. Acceptable documentation for the effective date of the policy includes an official letter from the insurance company or agent, or, a screen shot or printout from a billing or insurance verification system, a medical facility, or an insurance database.

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**

Patient: ______________________ CRDP ID Number: RX ____________
DOB: ___/___/___ Social Security #:

(X)	ITEM TO BE CHANGED	NEW INFORMATION
	ADDRESS	HOME ADDRESS: ______________ APT #: ____ CITY: ______________ STATE: ____ ZIP CODE: __________ TELEPHONE: __________
	DIALYSIS ☐ CENTER ☐ TREATMENT CHANGE IN TREATMENT:	CENTER NAME: __________ NPI # __________ __FIRST DATE OF DIALYSIS AT NEW CENTER: DATE BEGAN: ___/___/____ __HOME DIALYSIS __IN CENTER TREATMENTS PER WEEK # _____ ___HEMO ___CAPD (A) ___CCPD (C) ____REJECTED TRANSPLANT DATE WITHDRAWN FROM THIS CENTER ___/___/___ DID PATIENT ENTER A NEW CENTER? ☐ YES ☐ NO
	TRANSPLANT	DATE OF TRANSPLANT: ___/___/___ DATE RETURN TO DIALYSIS: ___/___/___ DATE OF REJECTION: ___/___/___ INSTITUTION NAME & ADDRESS: ______________
	MEDICARE A, B, C, D OR PRIVATE INSURANCE INFORMATION ☐ CHANGE ☐ PRIMARY ☐ ADD ☐ SECONDARY ☐ DELETE ☐ MED PART D	NAME OF 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: ______________ IF THERE IS A CHANGE IN COVERAGE, 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 HUMAN SERVICES, ETC.
	DEATH	DATE OF DEATH: ___/___/___
	PERSON COMPLETING THIS REPORT	NAME: ______________ PHONE#: __________ ADDRESS: ______________ SIGNATURE: ______________ DATE: __________