

CARDHOLDER ENROLLMENT APPLICATION

This Application is for initial enrollment in the Chronic Renal Disease Program (CRDP). **This application will not be accepted for re-enrollment.**

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.

CRDP ELIGIBILITY REQUIREMENTS

CITIZENSHIP *(proof required)*

To be eligible for the CRDP, you must be a U.S. Citizen or Legal Alien (admitted under the Immigration Reform and Control Act of 1986 (IRCA) or qualify for refugee/asylum status). Submit a photocopy of one of the following documents for proof of citizenship (Do not send originals. 8½" x 11" photocopies are preferred.):

- Birth certificate
- Naturalization papers
- Immigration and Naturalization Service documents
- PA Department of Human Services Medical Assistance identification card
- U.S. passport
- School record
- Military service documents showing date of birth
- Notarized statement
- Voter registration card
- Religious record showing date of birth

Example:

- Tribal record issued on Indian Reservation
 - Baptismal certificate
-
- Any document from the Social Security Administration showing name, Social Security number, etc. (except a Social Security card)

RESIDENCY *(proof required)*

To be eligible for the CRDP, you must have lived in Pennsylvania at least 90 days prior to the date of this application or must be able to show an intent to maintain a permanent home in Pennsylvania for the indefinite future

Submit a photocopy of one of the following documents for proof of residency. (Do not send originals. 8½" x 11" photocopies are preferred.) Documents cannot be older than two years:

- Federal, state or local income tax return with a pre-printed name and address label
- Driver's license or vehicle owner's card
- Utility receipts
- Pre-printed rent receipts
- Long-term care residents may submit a letter on the facility's stationery, signed by the director or administrator, stating admission date
- Unemployment Compensation card
- Dated PA Department of Human Services correspondence
- Dated Social Security correspondence

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.

CRDP ELIGIBILITY REQUIREMENTS

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).**

A photocopy of 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 EMPLOYEES' 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.

- **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.

CRDP ELIGIBILITY REQUIREMENTS

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

ACCEPTABLE DOCUMENTS TO PROVE SOCIAL SECURITY NUMBER

- Social Security card
- Social Security Administration 1099 or SSA-100 Statement
- W-2 Wage and Tax Statement
- 1099 or 1099-R Pension Statement
- Current pay stub identifying applicant's name, address and Social Security number.

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.

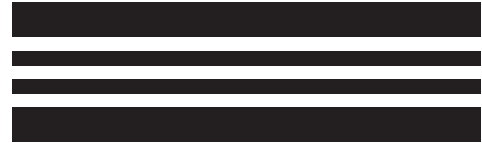
INSTRUCTIONS FOR COMPLETING THE CRDP APPLICATION

IMPORTANT: Must type or print with black ink.

- A** Print your name, Social Security number (you must enclose a photocopy of your Social Security card), home address, birth date, and telephone number. When entering your birth date, please use the number for the month, day and year. (Example: If your birth date is February 23, 1941, enter 02/23/1941.)
- 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. 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. Be sure to include all information requested. **Note:** Proof of policy effective date is **required** for all health coverage programs. Please see the table on page 13 for a list of acceptable proof of coverage.
- F** **EVIDENCE OF INCOME:** 8½" 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:** Power of Attorney or guardianship documentation must accompany the application 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.



CARDHOLDER
APPLICATION



MUST TYPE OR PRINT WITH BLACK INK

A	LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
	HOME ADDRESS (PROOF REQUIRED)			APARTMENT #
				BIRTH DATE (MM) (DD) (YYYY) / /
CITY			STATE	ZIP
				HOME PHONE ()
B	SPOUSE'S NAME			CITIZENSHIP STATUS
	SPOUSE'S SOCIAL SECURITY #			<input type="checkbox"/> US CITIZEN <input type="checkbox"/> LEGAL ALIEN <input type="checkbox"/> OTHER (EXPLAIN)
C	RACE (CIRCLE ONE) (OPTIONAL)	ETHNICITY (OPTIONAL) (CIRCLE ONE)	D SEX (CIRCLE ONE)	MARITAL STATUS (CIRCLE ONE)
	1 AMERICAN INDIAN/ALASKAN NATIVE 2 ASIAN/PACIFIC ISLANDER 3 BLACK/AFRICAN AMERICAN 4 WHITE 5 MULTIRACIAL/OTHER 6 UNKNOWN	1 HISPANIC ORIGIN 2 NOT OF HISPANIC ORIGIN		1 MALE 2 FEMALE
E	HEALTH COVERAGE: Complete "Health Coverage Information Sheet" and attach photocopies of all Insurance cards to the application			
F	EVIDENCE OF INCOME: (PROOF REQUIRED) (MARRIED PERSONS LIVING TOGETHER MUST REPORT COMBINED INCOME EVEN IF FILING SEPARATE FEDERAL 1040 INCOME FORMS)			
<p>Indicate number of individuals residing in household: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Did you file a federal 1040 income tax form for the prior calendar year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Did you claim any dependents on your 1040 for the prior calendar year? If "Yes," how many dependents did you claim? _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Did anyone else claim you as a dependent on a 1040 for the prior calendar year?</p>				
				INCOME
1	Total Prior Calendar Year Gross Social Security - Include Medicare Premiums and Supplemental Security Income (SSI)			
2	Total Prior Calendar Year Gross Railroad Retirement Benefits (RRB-1099 and RRB-1099R Form)			
3A	Total Prior Calendar Year SERS Pension (State Employees' Retirement) This applies to retired State Employees Only			
3B	Total Prior Calendar Year PSERS Pension (Public School Employees' Retirement) This applies to Retired Public School Employees Only			
4	Total Prior Calendar Gross Pensions (not listed in 3A & 3B above), and Taxable Amount of All Annuities and IRAs			
5	Total Prior Calendar Year Interest, Dividends, Capital Gains and Prizes			
6	Wages, Salary Bonuses, Commissions, Self-employment, Partnerships, Net Rental Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony Support, Gambling, Gifts & Inheritance over \$300 & Death Benefits over \$5,000			
7	TOTAL ANNUAL INCOME (Add lines 1 through 6)			
G	By signing, I know 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.			
H	APPLICANT SIGNATURE (MUST BE SIGNED OR MARKED WITH AN X)			WITNESS/PREPARER'S SIGNATURE AND PHONE #
	DATE ____/____/____ (MM) (DD) (YYYY)			
POWER OF ATTORNEY OR COURT-APPOINTED GUARDIAN MAY SIGN FOR APPLICANT (PROOF REQUIRED)				<input type="checkbox"/> Physician's Statement Attached

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 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.

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.

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
DIABETES		TRANSPLANT COMPLICATIONS	
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
GLOMERULONEPHRITIS		HYPERTENSION/LARGE VESSEL DISEASE	
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	CYSTIC/HEREDITARY/CONGENITAL/OTHER DISEASES	
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	DISORDERS OF MINERAL METABOLISM	
N04.8	Nephrotic syndrome with other morphologic changes	E83.52	Hypercalcemia
N04.9	Nephrotic syndrome with unspecified morphologic changes	GENITOURINARY SYSTEM	
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
SECONDARY GLOMERULONEPHRITIS/VASCULITIS		ACUTE KIDNEY FAILURE	
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	MISCELLANEOUS CONDITIONS	
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
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS		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
NEOPLASMS/TUMORS		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
C88.2	Heavy chain disease		

THIS PHYSICIAN'S STATEMENT MUST BE RETURNED WITH YOUR APPLICATION

Patient's Name: _____

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. PLEASE USE THE LIST OF ACCEPTABLE ICD-10-CM 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 _____

ENTER DATE OF FIRST DIALYSIS TREATMENT: _____
MM DD YYYY

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.

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 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

Facility NPI required for dialysis patients

Dialysis/Transplant/Treating Physician Facility Name _____

Address _____

City _____ State _____ Zip Code + Four _____

Phone # (_____) _____

Social Worker/Transplant Coordinator/Treating Physician Office Email: _____

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. Must show your name
- b. Must show the effective date of coverage

A screenshot from a personal online insurance portal

- a. Must show your name
- b. Must show the effective date of coverage

A copy or screenshot from a billing system or insurance verification system. (A Medical provider or social worker can provide this documentation as well)

- a. Must show your name
- b. Must show the effective date of coverage

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)?
- Included proof of policy effective date for each health coverage program?
- Included a photocopy of your Social Security card or proof that you have applied for a Social Security number?
- Included a photocopy of proof of citizenship?
- Included a photocopy of proof of residency?

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