pennsylvania
DEPARTMENT OF HEALTH

CRDP
Chronic Renal Disease Program

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 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.

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. 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:** "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.

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

ICD-10	Description
Q87.1	Congenital malformation syndromes predominantly associated with short stature
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

THIS PHYSICIAN'S STATEMENT MUST BE RETURNED WITH YOUR APPLICATION

Patient's Name:_____

Application for Services

Patient's Identification Number RX:_____

CONFIDENTIAL

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 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

☐☐☐.☐☐☐☐ _____

Please Check One

☐ Changes to patient treatment status (Complete Form)

☐ No Changes to patient treatment status (Complete Physician Signature and Associated NPI Information)

A physician must sign and date this page for any change(s) that has/have been made.

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

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

NUMBER OF TREATMENTS PER WEEK: _____

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.

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 ☐☐☐☐☐☐☐☐☐☐ **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

Attach copies of all identification cards for medical and prescription health coverage listed below. Attach proof of policy effective date for each health coverage program not previously reported to the CRDP if effective date not on card.

THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR CRDP APPLICATION

HEALTH COVERAGE INFORMATION SHEET

Patient's Name: _____

Patient's RX Number: RX☐☐☐☐☐☐☐

Place a checkmark (√) in the box to indicate all health programs in which you are enrolled. Provide the effective date for each program and all information requested.

DO NOT INCLUDE THE CRDP PROGRAM AS HEALTH OR PRESCRIPTION COVERAGE.

☐ **I HAVE NO MEDICAL INSURANCE, PRESCRIPTION OR OTHER HEALTH COVERAGE PROGRAMS**

√ **NAME OF PROGRAM**	**IDENTIFICATION NUMBERS**
☐ Medicare Part A Effective Date: _____ (MM DD YYYY) ☐ Medicare Part B Effective Date: _____ (MM DD YYYY)	List Medicare Claim Number below: _____ This number is located on your Medicare Card
☐ Medicare Advantage Plan (HMO) Effective Date: _____ (MM DD YYYY) _____ Name of Medicare Advantage Plan	Identification Number: _____
☐ Medicare Part D Prescription Effective Date: _____ (MM DD YYYY) _____ Name of Medicare Part D Prescription Plan	Identification Number: _____ ℞ Group Number: _____ Bin #: _____ PCN #: _____
☐ PA Department of Human Services Medical Assistance Program	Access Number: _____ Effective Date: _____ (MM DD YYYY)
☐ United States Veterans Administration	File Number (C#): _____ Effective Date: _____ (MM DD YYYY)
☐ Other Insurance: **Please List Below**	

PRIMARY HEALTH INSURANCE CARRIER	**SECONDARY HEALTH INSURANCE CARRIER**
_____ Policyholder's Name: Last, First, Middle Initial ___-___-___ Social Security #	_____ Policyholder's Name: Last, First, Middle Initial ___-___-___ Social Security #
Basic Medical/Hospital Plan Effective Date: _____ (MM DD YYYY)	Basic Medical/Hospital Plan Effective Date: _____ (MM DD YYYY)
Name of Carrier: _____	Name of Carrier: _____
Policy # _____ Group # _____ Plan _____	Policy # _____ Group # _____ Plan _____
Prescription Plan? Yes No	Prescription Plan? Yes No

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 not previously reported to the CRDP?**

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