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: **1-888-656-0372**

Patient: _____ DOB: / /		CRDP ID Number: RX _____ 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CENTER: DATE BEGAN: I I HOME DIALYSIS IN CENTER TREATMENTS PER WEEK # HEMO CAPD (A) CCPD (C) REJECTED TRANSPLANT DATE WITHDRAWN FROM THIS CENTER ___/___/___ DID PATIENT ENTER A NEW CENTER?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 AND ADDRESS: _____ NPI: _____
	MEDICARE A, B, C, D OR PRIVATE INSURANCE INFORMATION ☐ CHANGE ☐ ADD ☐ 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: _____