

This form must be submitted through a KHC provider. (See KHC Rules §61.2(37) for definition of provider.)



# KIDNEY HEALTH CARE – APPLICATION FOR BENEFITS

Texas Department of State Health Services (MC 1938) P.O. Box 149347, Austin, Texas 78714-9347  
Phone 512-776-7150 Toll-free 1-800-222-3986

<b>Name of Applicant:</b>	Last _____	<b>KHC Use Only</b>
	First _____	
	Middle _____ Suffix _____ <small>(Jr., Sr., I, II)</small>	
<b>SSN:</b> _____	<b>Marital Status:</b> _____	KHC Client Number: <b>8</b>
<small>(W, M, S, D)</small>		

## ADDRESS

Does applicant reside in a Nursing Home?  Yes  No

**Home Address** Street (Physical Location): \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Is Mailing Address same as Home Address?  Yes  No

If no, **Mailing Address** P.O. Box/Street: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_

If other than applicant, address correspondence **In Care Of:** \_\_\_\_\_

## APPLICANT INFORMATION

Do you have coverage other than Medicare or Medicaid?  Yes  No

Are you a Texas Resident?  Yes  No Date you became a Texas Resident: \_\_\_\_\_

Applicant is:  U.S. Citizen  Other  
 (Optional)  U.S. Non-Citizen National  
 Qualified Alien (usually permanent resident alien or refugee)

Preferred Language:  English  Spanish  Other

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

SSN Document enclosed:  Medicare Card (Medicare # -in applicant's own SSN- must be imprinted on card)  
 SSA Document  
 Social Security Card

## RESIDENCY DOCUMENTS

**List and attach one document (See Residency Documents list on page 2 of Application Instructions)**

Document: \_\_\_\_\_ Name on document  Applicant  Relation  
 Date and/or expiration date: \_\_\_\_\_ **If Relation, Name:** \_\_\_\_\_  
 Contains Texas address of applicant  Yes  No  Adult Child  Guardian  Other  Parent  Spouse  
 Supporting document: \_\_\_\_\_

**Attach a completed, signed and dated HCFA 2728 form**



**INSURANCE INFORMATION**

<b>Type of Policy</b>	<input type="checkbox"/> Other	<input type="checkbox"/> Group	<input type="checkbox"/> Medical Assistance
	<input type="checkbox"/> Government	<input type="checkbox"/> Individual	<input type="checkbox"/> Medicare Supplement
<b>Insurance Company</b>	Name: _____		
	Phone: (____) _____		Effective date: _____
	Address: _____		
	Policy/ID#: _____	Group Name: _____	
	Group #: _____	Term. Date: _____	
	Zip Code: _____	City: _____	State: _____
<b>Insured Person</b>	Insured's Name: _____		
	Insured's SSN: _____		
<b>Pre-Existing ESRD:</b>	<input type="checkbox"/> None	<input type="checkbox"/> Temporary - End Date _____	<input type="checkbox"/> Permanent
<b>PPO/HMO :</b>	Office Visit Copay	Other Outpatient Coverage _____%	Inpatient Coverage _____% Deductible \$ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____		
<b>Drug Coverage</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Generic Benefit: Coverage: _____%	Copay: \$ _____
		Brand Benefit: Coverage: _____%	Copay: \$ _____
		Calendar Year Max: \$ _____	Other Max: \$ _____ Deductible: \$ _____
<b>Major Medical or Indemnity Coverage:</b> Outpatient: _____% Inpatient: _____% Deductible: \$ _____			

**Disclosure of Social Security Number**

A copy of the applicant's personal Social Security card (or allowable substitute) which identifies the applicant's Social Security Number (SSN) is a mandatory requirement for a complete application for KHC benefits. This mandatory disclosure of the applicant's SSN is authorized by the Kidney Health Care Act, Chapter 42, Section 42.007, and KHC Rules, Section 61.4(1)(D)(i)-(ii).

The SSN is needed to coordinate hospitalization and medical benefits between KHC and other third-party payors such as an insurance policy, individual health plan, group health plan, Title XVIII (Medicare) and/or Title XIX (Medicaid) under the Social Security Administration, Veteran's Administration benefits, state or municipal government public health programs, etc., as authorized by the KHC ACT, Sections 42.002 and 42.009, and KHC rules, Section 61.4.

**Applicant Statement of Assurances**

I have read this application and I understand its meaning. At the time of my signature, the application was complete to the best of my knowledge. (If someone signs this application for the applicant, please explain why and the relationship to the applicant). I certify that:

1. All information presented herein may be released by Kidney Health Care (KHC) for verification purposes.
2. I give permission to the Kidney Health Care Program to communicate with and release information to appropriate agencies, organizations, physicians and other health professionals on my behalf. This information will be held confidential and will ultimately be used for my benefit.

3. By assigning my KHC benefits to providers, I authorize them to receive reimbursement from KHC on my behalf.

4. I have been informed of or have read the Kidney Health Care rules and know that they are available for review at my facility and I have had an opportunity to ask questions about the rules.

I understand that this application is a legal document and that by signing it under oath before a Notary Public I am stating that, to the best of my knowledge, all statements made on the KHC application are true and correct. I also understand that if I have made false statements, this may be a crime punishable under the laws of the State of Texas.

**PRIVACY NOTIFICATION**

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

**Applicant Signature**

X \_\_\_\_\_  
 (If applicant is a minor or under legal guardianship, the above signature line is for the parent, managing conservator of legal guardian.)

\_\_\_\_\_  
Date

**Notary Information**

Subscribed and sworn to before me on this, the \_\_\_\_\_ day of \_\_\_, to certify which witness my hand and official seal of office.

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Print Name

**Notary Public in and for**

\_\_\_\_\_  
County/Parish

\_\_\_\_\_  
State

\_\_\_\_\_  
Commission Expires

Seal/Stamp

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## ADDENDUM FOR MEDICARE PART D

Has this KHC applicant enrolled in Medicare Part D? (Choose only **one** option.)

**Did Not Enroll (Check “Did not Apply/Not Enrolled” in ASKITWeb)**

**Reason:**  Other creditable coverage (Must complete insurance section on page 3.)

Did not know I could

Other \_\_\_\_\_

**Pending Enrollment (Check “Applied/Pending Enrollment” in ASKITWeb)**

Prescription drug company name: \_\_\_\_\_

Benefit plan name: \_\_\_\_\_

Date applicant mailed in enrollment form: \_\_\_\_\_

**Enrolled (Check “Approved/Enrolled” in ASKITWeb).**

**Complete all of the following three sections.**

**SECTION 1:** Fill in the blanks below using the applicant's Medicare Part D insurance card.

Member's ID number\*: \_\_\_\_\_ Plan start date: \_\_\_\_\_ (mm/dd/yyyy)

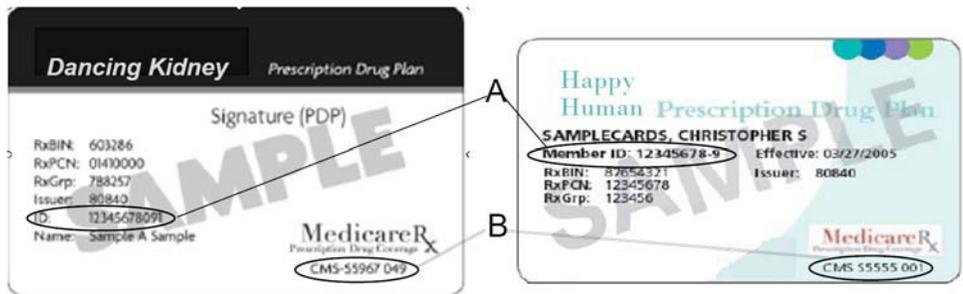
PDP and Benefit Plan Number\*: \_\_\_\_\_

(\*These appear in the bottom right-hand corner of the client's Medicare card as shown in the examples.)

**Examples**

**A:** Member's ID

**B:** PDP and Benefit Plan number



NOTE: If applicant does not have the PDP and Benefit Plan number, you must complete this section: (Otherwise it is optional.)

Prescription drug company name: \_\_\_\_\_

Benefit plan name: \_\_\_\_\_

**SECTION 2:** Is the applicant covered by a QMB, SLMB, or QI Medicare Savings Program?

**Yes.** (If yes, go to part 3.)

**No.**

Has this KHC applicant applied for the low-income subsidy (extra help) from Social Security?

**Yes.** What is the subsidy level that CMS pays?

**25%**  **50%**  **75%**  **100%**  **pending**  **denied**

**No.**

**SECTION 3:** Is any part of the premium paid by an automatic deduction (such as from a monthly Social Security benefit or bank draft)?

**Yes.** (If yes, please tell applicant that KHC cannot pay their premiums.)

**No.**