NATIONAL KIDNEY FOUNDATION OF ARIZONA

Renal Transplant Medications Program Intake/Eligibility Form

Patient's Full Name: _____

Race/Ethnicity: _____ Male _____ Female _____

Birthdate: _____

Medicare Number: _____

Fry's Pharmacy Location/Store Number: _____

Proof of United States Citizenship (please provide a copy of one of the following):

□ Social Security Card
□ Birth Certificate
□ Driver's License
□ Legal Permanent Resident

Confirm medical insurance/assistance program status (check all that apply):

□ Veterans Administration & Indian Health Services resources have been exhausted
□ Client is not currently enrolled in AHCCCS
□ Client has an AHCCCS application pending
□ Client is ineligible for AHCCCS/Medicare (Client has a letter of denial from AHCCCS/Medicare - make a copy for eligibility file)
□ Client has Medicare (immunosuppressant coverage only)
□ Client has Medicare only without immunosuppressant coverage (not Medicare at time of Transplant
□ Client has Medicare Part D insurance with co-pay and deductible requirement
□ Client has commercial insurance with a pharmacy deductible or co-pay requirement
□ Client has commercial insurance, but no pharmacy benefits (List carrier and copy letter from commercial insurance company denying coverage or benefits):
□ Client has no insurance
□ Client has applied for coverage through the Health Insurance Marketplace
□ Client has applied for PAN, HealthWell Foundation or other assistance programs (specify status of applications)

_____

□ Client has applied for drug manufacturer assistance programs (specify status of applications)

_____

Submit documentation of the status of medical insurance/assistance program applications or other coverage opportunities when applying for renewal of NKF AZ assistance. Patients who do not apply for insurance coverage and/or assistance programs they may be eligible for will not have their assistance from NKF AZ renewed.

_____

Transplant Social Worker Signature Date

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PHARMACY COVERAGE (including MEDICARE PART D)

Please complete and include all of the information listed below ***including a copy of pharmacy coverage card(s).*** If you enroll in/change pharmacy coverage in the future, it is imperative that you notify your transplant social worker immediately to eliminate any problems in obtaining your medications and/or incorrect billing.

Primary Plan Name: _____

Plan Telephone#: _____Patient's Rx BIN #_____

Plan or Member ID #: _____

Insurance Group #: _____PCN # (if available) _____

Co-pays: Generic: _____ Brand: _____ Non Formulary: _____
(These co-pay dollar amounts must be filled out)

Secondary Plan Name: _____

Plan Telephone#: _____Patient's Rx BIN # _____

Plan or Member ID #: _____

Insurance Group #: _____PCN # (if available) _____

Co-pays: Generic: _____ Brand: _____ Non Formulary: _____
(These co-pay dollar amounts must be filled out)

Tertiary Plan Name: _____

Plan Telephone#: _____Patient's Rx BIN # _____

Plan or Member ID #: _____

Insurance Group #: _____PCN # (if available) _____

Co-pays: Generic: _____ Brand: _____ Non Formulary: _____
(These co-pay dollar amounts must be filled out)

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Statement of Understanding

I affirm that the information I have provided to qualify for the NKF AZ Renal Transplant Medications Program is accurate and true to the best of my knowledge. I understand that if I have willfully falsified this application, I may be disqualified from the program. I understand that this program covers **only** anti-rejection and transplant related medications prescribed by a medical doctor for **transplant-specific** indications. Hormones, vitamins, tranquilizers, sleeping aids, anti-depressants, inhalers, seizure medications, ointments and over-the-counter medications are not covered under this program. I also affirm that I have exhausted all other medications assistance resources.

I understand that I must apply for insurance coverage and any other assistance programs that I may be eligible for or my assistance from NKF AZ will not be renewed.

I understand that eligibility is based on the availability of funding, and coverage is provided on no more than a quarterly basis. Reapplication is available and requires proof that all other medications assistance resources have been exhausted.

_____ _____
Client Signature (Parent or Guardian, if minor) Date

_____
Printed Name of Client

_____ _____
Transplant Social Worker Signature Date

_____
Printed Name of Transplant Social Worker