

TRANSPLANT APPLICATION

Type of Transplant:
 Kidney Pancreas
 Heart/Kidney

PATIENT INFORMATION		Name: _____	
Social Security #:	Date of Birth:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone #:	Cell #:	Email: _____	
U.S. Citizen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Resident Alien:	<input type="checkbox"/> Yes <input type="checkbox"/> No Language Preference: _____
Address:	Apt.#	City:	State: Zip:
Height:	Weight:	Name of Spouse:	Phone #:
Emergency Contact:		Phone #:	

MEDICARE/MEDICAID INFORMATION		<i>(Please include a copy of all insurance cards)</i>	
Medicare ID #:	Effective Date:		
Medicaid ID #:	Effective Date:		
Texas Kidney Health Plan #:	Date of First Dialysis:		

INSURANCE INFORMATION		SECOND INSURANCE INFORMATION	
Insurance Co.:	Insurance Co.:		
Customer Service #:	Customer Service #:		
Policy # / I.D. #	Policy # / I.D. #		
Group #:	Group #:		
Address:	Address:		
City: State: Zip:	City: State: Zip:		
Effective Date:	Effective Date:		

REFERRING AGENTS			
Referring Physician:	Group Practice Name:		
Address:	City:	State:	Zip:
Phone #:	Fax #:		
Name of Dialysis Center:	Phone Number:		
Dialysis Center Social Worker:			
Type of Dialysis:	<input type="checkbox"/> Not yet on dialysis	<input type="checkbox"/> Peritoneal	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Home Hemodialysis
Dialysis Days:	<input type="checkbox"/> M/W/F <input type="checkbox"/> T/Th/Sat	Dialysis Time: _____	
Previous Transplant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Location: _____	Date: _____

RELEASE OF INFORMATION - Patient Request to Begin Evaluation and Financial Clearance Process:			
<p>I request that Medical City Dallas Transplant Center begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start the transplant process. I authorize my physicians to release my medical records to Medical City Transplant Center. I authorize Medical City Transplant Center to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment, or any other such related information to: 1) Medicare; 2) Medicaid; 3) my insurance company or it's designated representatives; 4) any person (s) or entities financially responsible for my care or treatment. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at Medical City Transplant Center. I further authorize release of this information to health care providers associated with my care outside of Medical City Transplant Center.</p>			
Patient Signature: _____	Witness Signature: _____		
Print Name: _____	Date: _____	Print Name: _____	Date: _____

REQUIRED DOCUMENTS*(Please include a copy of the following required documents)*

- Copy of the front and back of all insurance cards
- Copy of social security card
- Copy of Texas I.D. or drivers license (if available)
- Copy of resident alien card (if applicable)
- Copy of 2728 if currently receiving dialysis treatments

FAX REFERRAL FORM TO: 972.566.4872

Mail completed application to:
Medical City
Transplant Services
7777 Forest Lane, Bldg. C-750
Dallas, Texas 75230
1-800-348-4318



7777 Forest Lane • Suite C-750
Dallas, Texas 75230 • (972) 566-7199

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