

TRANSPLANT APPLICATION

Type of Transplant:

Kidney Heart/Kidney Pancreas

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:	Dialysis Start Date:
Previous Transplant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Location:	Date:

Consent - Patient Request to Begin Evaluation and Financial Clearance Process:

I request that Medical City Dallas Transplant Center begin the financial clearance process and transplant evaluation for me. I understand my insurance companies will be contacted in order to start the transplant process.

Patient Signature: _____ Witness Signature: _____
 Print Name: _____ Date: _____ Print Name: _____ Date: _____

REQUIRED DOCUMENTS		<i>(Please include a copy of the following required documents)</i>	
<input type="checkbox"/> Copy of the front and back of all insurance cards	<input type="checkbox"/> Copy of 2728 if currently receiving dialysis treatments	<input type="checkbox"/> Copy of social security card	<input type="checkbox"/> Copy of most recent dialysis note or physician note
<input type="checkbox"/> Copy of I.D. or drivers license (if available)	<input type="checkbox"/> Copy of authorization of records release form	<input type="checkbox"/> Copy of resident alien card (if applicable)	<input type="checkbox"/> Copy of current medication list

FAX REFERRAL FORM TO: 972.566.4872
 Mail completed application to: Medical City Dallas • Transplant Institute • 7777 Forest Lane, Bldg. C-750
 Dallas, Texas 75230 • 1-800-348-4318



PATIENT IDENTIFICATION

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* T P L S *

White - Medical City

Yellow - Dialysis Center

MCD-RD770-00288 (Rev. 08/19)