

## KIDNEY TRANSPLANT APPLICATION

I would like to be considered for: Kidney      Pancreas      Kidney & Pancreas  
I would like to have my evaluation testing in: Temple      Round Rock

PATIENT INFORMATION		Name:	
Address:	Apt #:	City:	State:
Social Security #:		Date of Birth:	Sex: Male Female
Race:	White Black Asian American Indian/Eskimo/ALEU Hawaiian Native/Pacific Islander Other		
Ethnicity:	Hispanic Origin Not of Hispanic Origin		
Phone #:	Cell #:	E-mail:	
U.S. Citizen:	Yes No	Language Preference:	Do you speak English: Yes No
Emergency Contact:	Phone #:		

MEDICARE/MEDICAID INFORMATION (Please include a copy of all insurance cards)		
Medicare ID#:	Medicaid ID#:	Texas Kidney Health Plan #:

INSURANCE INFORMATION	
Primary Policy Holder's Name:	Date of Birth: Social Security #:
Insurance Company:	Customer Service #:
Policy / ID #:	Group #:

ADDITIONAL INFORMATION		Referring Physician:	
Address:	City:	State:	Zip:
Phone #:	Fax #:		
Name of Dialysis Center:	Phone #:	City:	
Dialysis Center Social Worker:			
Type of Dialysis:	Not yet on dialysis Peritoneal Hemodialysis Home Hemodialysis	Height:	Weight:
Dialysis Days:	M/W/F T/Th/Sat	Date of first dialysis:	
Previous Transplant:	Yes No If Yes, Transplant Center:	City:	Date:

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS	
<p>I request that Scott &amp; White Medical Center – Temple begins the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start this process. I authorize my physicians to release my medical records to Scott &amp; White Medical Center – Temple and Scott &amp; White Clinics. I authorize Scott &amp; White Medical Center – Temple and Scott &amp; White Clinics 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) Representatives of local, state or federal agencies in accordance with law; 2) Medicare; 3) Medicaid; 4) my insurance company or its designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and/or representatives of Scott &amp; White Medical Center – Temple and Scott &amp; White Clinics, for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Scott &amp; White Medical Center Temple and Scott &amp; White Clinics and/or any member of the medical and house staff at Scott &amp; White Medical Center and Scott &amp; White Clinics; and/or 7) individuals or entities for quality improvement, educational, medical research, accreditations or other purposes customarily utilized by hospitals and medical staffs in carrying out their functions. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for any medical expenses incurred at Scott &amp; White Medical Center and Scott &amp; White Clinics. I further authorize release of this information to health care providers associated with my care outside Scott &amp; White Medical Center and Scott &amp; White Clinics to facilitate further health care.</p>	
Patient Signature:	Date:
Print Name:	

REQUIRED DOCUMENTS (Please provide a copy of the following required documents)	
Copy of Government Issued I.D. such as Drivers License or Passport Copy of Insurance Card(s) – front and back	<b>If on Dialysis:</b> Recent History of Compliance TB Test (within past year) Copy of HCFA 2728 Form
Recent History and Physical from Nephrologist (within past year)	<b>If Not on Dialysis:</b> eGFR or 24 Hour Creatinine Clearance
Most Recent Height and Weight from Nephrologist or Dialysis Center	

**Mailing Address for  
Scott & White Medical Center  
Transplant Services:**

2401 S. 31st Street  
Temple, TX 76508  
Phone: 254.724.8912  
Fax: 254.724.4153  
Or email to [transplant@BSWhealth.org](mailto:transplant@BSWhealth.org)