TRANSPLANT APPLICATION

Type of Transplant:
☐ Kidney ☐ Heart/Kidney ☐ Pancreas

PATIENT INFORMATION	Name:	
Social Security #:	Date of Birth:	Sex: ☐ Male ☐ Female
Phone #:	Cell #:	Email:
U.S. Citizen: ☐ Yes ☐ No	Resident Alien: ☐ Yes ☐ No	Language Preference:
Address: Apt.#	City:	State: Zip:
Height: Weight:	Name of Spouse:	Phone #:
Emergency Contact:	Phone #:	
MEDICARE/MEDICAID INFORMATION	***(Please include a copy of all insurance cards)***	
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: ☐ Not yet on dialysis ☐ Peritoneal ☐ Hemodialysis ☐ Home Hemodialysis		
Dialysis Days: ☐ M/W/F ☐ T/Th/Sat	Dialysis Time:	Dialysis Start Date:
Previous Transplant: ☐ Yes ☐ 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 ***(Please include a copy of the following required documents)***

☐ Copy of the front and back of all insurance cards	☐ Copy of 2728 if currently receiving dialysis treatments
☐ Copy of social security card	☐ Copy of most recent dialysis note or physician note
☐ Copy of I.D. or drivers license (if available)	☐ Copy of authorization of records release form
☐ Copy of resident alien card (if applicable)	☐ Copy of current medication list

FAX REFERRAL FORM TO: 469-484-2235

Mail completed application to: Medical City Dallas • Transplant Institute • 7777 Forest Lane, Bldg. C-240
Dallas, Texas 75230 • 1-800-348-4318

Medical City Dallas Medical City Children's Hospital

7777 Forest Lane • Dallas, Texas 75230 • (972) 566-7000

PATIENT IDENTIFICATION

TRANSPLANT APPLICATION

* T P L S *

White - Medical City **Yellow -** Dialysis Center