

American Kidney Fund
6110 Executive Boulevard
Suite 1010
Rockville, Maryland 20852





301.881.3052 voice
301.881.0898 fax
800.638.8299 toll-free
866.300.2900 Español
www.kidneyfund.org
Member: CFC 11404

American Kidney Fund Application Faxing Guidelines

In an effort to optimize our paperless fax system and insure that all requests are processed in a timely fashion, it is imperative that you follow these guidelines when submitting a request to the American Kidney Fund (AKF) via Fax:

- Please be sure that you do not write on or mark up the area surrounding the application code in the top right and bottom left hand corner of the application (see example below). Any marking of this area will result in the paperless fax system misreading this form and may result in a delay in the processing of your request.

	HRC Do Not Write in this Area	
HIPP Request Form		
Mail or fax completed form to: AKF Patient Services, 6110 Executive Blvd., #1010, Rockville, MD, 20852 Fax: (301) 881-3311 Questions? Phone 1-800-795-3226 or Email: patientservice@kidneyfund.org		
HIPP Liaison _____	Social Worker _____	
Facility Name _____		
Corporate Affiliation _____		
Street Address _____		
City, State, Zip _____		
Telephone _____	Fax _____	
Date ____/____/____		
Please check all that apply:		
<input type="checkbox"/> First time request (submit w/ HIPP Application and Bill)	<input type="checkbox"/> Requesting Reissue for Check # _____	
<input type="checkbox"/> Repeat payment request (submit w/ bill)	<input type="checkbox"/> One-Time Request	
<input type="checkbox"/> Balance due request	<input type="checkbox"/> Urgent Request (termination date ____/____/____)	
Patient's Name _____		
First	MI	Last
Patient's Social Security # ____ - ____ - ____		
Check one: Insurance Type: Primary <input type="checkbox"/> Secondary <input type="checkbox"/>		
<input type="checkbox"/> Monthly Premium Amt. \$ _____	<input type="checkbox"/> Bi-Monthly Premium Amt. \$ _____	<input type="checkbox"/> Quarterly Premium Amt. \$ _____
Make check payable to _____		
If check is payable to patient, provide insurance company name _____		
Check Address: _____		
Amount Requested \$ _____		
Coverage Period (from) ____/____/____ (to) ____/____/____		
Insurance Policy, ID or Claim # _____		
Comments: _____		
Do Not Write in this Area		
		

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- Please be sure that you are printing and using a new, clean copy of the application for each patient. Continuously copying the same application will distort the application code and will result in the paperless fax system misreading this form and thus delay the processing of your request.
- Please make sure that the fax machine that you are submitting the request from is not set to shrink the document in any manner. Shrinking the form will distort the application code and will result in the paperless fax system misreading this form and thus delay the processing of your request.

Please feel free to contact AKF's Patient Services Department at 1-800-795-3226, if you have questions.

Sincerely,
American Kidney Fund