



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:

- First time request (submit w/ HIPP Application and Bill)
Repeat payment request (submit w/ bill)
Balance due request
Requesting Reissue for Check #
One-Time Request
Urgent Request (termination date)

Patient's Name \_\_\_\_\_
First MI Last

Patient's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check one: Insurance Type: Primary Secondary

Monthly Premium Amt. \$ Bi-Monthly Premium Amt. \$ 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: \_\_\_\_\_

