GOLD KIDNEY HEALTH PLAN

Home Dialysis & Assisted Home Dialysis Referral Form

To refer a member for evaluation for home dialysis or assisted home dialysis services, complete this form and submit it using one of the methods below:

- **Email:** care_management@goldkidney.com
- **Fax:** 866-878-0051

You may also call Member Services at **(844) 294-6535 (TTY 711)**. A representative can assist you in completing the referral form and will forward the request to the Care Management Department for eligibility and program review.

Member Information		
Last Name:	First Name:	MI:
Date of Birth:	Phone:	Phone Type: ☐ Mobile ☐ Home ☐ Other
Email:		
Preferred Language: ☐ English ☐ Spanish ☐ Other:		
Is the individual currently enrolled with Gold Kidney Health Plan? ☐ Yes ☐ No ☐ Unknown If yes, Gold Kidney Health Plan Member ID:		

Referral Source		
☐ Self-Referral (Member)	☐ Caregiver/Family Member	☐ Gold Kidney Health Plan Staff
☐ Primary Care Provider	☐ Nephrologist	☐ Other Specialist
☐ Dialysis Clinic	☐ Hospital or Facility	☐ Other:

Referral Type *(Requested Dialysis Service)*	
☐ Home Hemodialysis	☐ Peritoneal Dialysis
☐ Assisted Home Hemodialysis	☐ Assisted Peritoneal Dialysis

Reason for Referral *(Select all that apply)*	
☐ Member interested in home dialysis	☐ Member interested in assisted home dialysis
☐ Nephrologist or provider recommendation	☐ Difficulty attending in-center dialysis
☐ Transportation barrier	☐ Functional/Mobility limitation
☐ Frequent missed in-center dialysis treatments	☐ Potential improvement in quality of life
☐ Potential improvement in independence	☐ Other:

Care Partner Information	
A care partner may be a family member, caregiver, or trained support person who assists a member with home dialysis treatment and related tasks.	
1. Does the member currently have a potential care partner? ☐ Yes ☐ No ☐ Unknown If yes, is the care partner willing and available to participate in training? ☐ Yes ☐ No ☐ Unknown	
If yes, Care Partner Name:	
Relationship to Member:	Phone:
2. Does the member need assistance identifying or arranging a care partner? ☐ Yes ☐ No ☐ Unknown	

Current Dialysis Status and Modality			
☐ Dialysis planned but not yet started	☐ In-Center Hemodialysis	☐ Home Hemodialysis	☐ Peritoneal Dialysis

Clinical Information		
Primary Diagnosis:		
Secondary Diagnosis:		
Has the member been diagnosed with end-stage kidney disease or end-stage renal disease? ☐ Yes ☐ No ☐ Unknown If yes, diagnosis date, if known:		
Nephrologist Information		
Nephrologist Name:	NPI:	
Practice/Facility Name:		
Contact Person Name:	Phone:	
Email:	Fax:	
Dialysis Center Information *(if applicable)*		
Dialysis Center Name:	NPI:	
Dialysis Center Address:		
City:	State:	ZIP Code:
Contact Person Name:	Phone:	
Email:	Fax:	
Acknowledgment		
By submitting this referral, I acknowledge that Gold Kidney Health Plan may contact the member or the member's authorized representative regarding evaluation for home dialysis or assisted home dialysis services.		
Name of Person Completing Form:		
Relationship to Member or Professional Title:		
Organization, if applicable:		
Email:		
Phone:	Date:	
Benefit Disclaimer: Home dialysis and assisted home dialysis services are subject to the member's eligibility and active enrollment in an applicable Gold Kidney Health Plan benefit plan at the time services are provided. Coverage is subject to applicable benefit limitations, medical necessity requirements, service frequency or quantity limits, service availability, and applicable plan policies. Submission of a referral does not guarantee eligibility, coverage, acceptance into a home dialysis or assisted home dialysis program, or payment.		