ANNUAL REPORT

Kidney Health Care Division

February 1, 1974

Texas State Department of Health

ANNUAL REPORT

KIDNEY HEALTH CARE DIVISION

A. Letters of Transmittal

B. Program Progress Report

C. Program Statistics

D. Financial Report

E. Exhibits

1. List of Advisory Committee Members
2. Map Showing Geographic Distribution of Approved Kidney Health Care Facilities
3. Kidney Health Care Recipient Identification Card
4. Copy of Policies and Procedures Booklet

Texas State Department of Health

JAMES E. PEAVY, M.D., M.P.H.
COMMISSIONER OF HEALTH

FRATIS L. DUFF, M.D., Dr. P.H.
DEPUTY COMMISSIONER

AUSTIN, TEXAS

February 1, 1974

J. E. Peavy, M.D., Commissioner
Texas State Department of Health
1100 West 49th
Austin, Texas 78756

Dear Doctor Peavy:

In compliance with section 3, paragraph 11 of the Kidney Health Care Act (Article 4477-20, VACS), we are pleased to enclose the ANNUAL REPORT documenting the activities of the Kidney Health Care Division. This report covers division activities from its beginning on September 1, 1973 to the present.

During this report period the organizational and development phase of the Kidney Health Care Division was completed and the program became fully operational.

Conclusive program evaluation would be difficult now due to the short operational time span, but it is already apparent that this program is well received by the medical community and is helping to meet the needs of Texans with chronic kidney disease.

Sincerely,

Philip W. Mallory

Philip W. Mallory, M.D.
Deputy Commissioner for Program Planning

JPR:en

Enclosure

THE UNIVERSITY OF TEXAS MEDICAL BRANCH
GALVESTON, TEXAS 77550

January 18, 1974

J. E. Peavy, M. D.
Commissioner of Health
Texas State Department of Health
Austin, Texas

Dear Doctor Peavy:

As Chairman of the State Advisory Committee on Kidney Health Care the submission of this first progress report is particularly significant.

We feel that the action taken thus far by the committee and the Kidney Health Care Division are fulfilling the intent of this landmark legislation, and denote a marked improvement in the health delivery system in our state.

Sincerely,

August R Remmers Jr

A. R. Remmers, Jr., M. D.
Professor of Medicine
Co-Director, Div. of Nephrology

ARR/dr

KIDNEY HEALTH CARE PROGRAM

In its regular session, the 63rd Legislature of the State of Texas passed the Kidney Health Care Act (Article 4477-20, VACS) which established within the Texas State Department of Health the Kidney Health Care Division.

This Division is funded by the current appropriations bill to provide for the "care and treatment of persons suffering from chronic kidney disease."

In order to bring to this program a high degree of medical expertise, a professional State Advisory Committee on Kidney Health Care was formed with the assistance of the Texas Medical Association, and its first working session was held prior to the program becoming operational.

At this initial meeting the Kidney Health Care Act was reviewed and a number of basic operational policies were suggested. Among these was a strong recommendation that this program should be structured to complement the new Federal Medicare Chronic Renal Disease Program by covering persons ineligible for Medicare, or costs incurred prior to Medicare eligibility. Also, the 20% of allowable charges and certain other expenses not covered by the Federal Program, would be borne by this program.

Following this meeting, eligibility criteria were established, program policies and procedural guidelines were written, and patient applications were designed.

These were adopted by the Board of Health on September 9, 1973, and during the following week this information, and patient applications, was provided to all interested parties and the 35 medical facilities which have been approved to participate in this program. Medical facility approval

is a function of the Medicare Certification and Consultation Division of the Texas State Department of Health and is based upon Federal Chronic Renal Disease Program requirements.

At this time 460 persons have been approved to receive benefits under the Kidney Health Care Program, and payments are beginning to be made to medical facilities, pharmacies, and other medical suppliers in behalf of persons covered by this program. In some cases, program recipients are being reimbursed directly for medical costs incurred.

No conclusions can yet be drawn concerning the yearly cost of this program because thus far only 56 of the 460 approved applicants have received any benefits and medical facilities are waiting for Federal Medicare payment to be made before billing this program.

A marked increase in the volume of bills received for payment has been experienced during the last month however, and it is expected that this trend will continue.

CUMULATIVE STATISTICS COMPILED FROM APPLICATIONS RECEIVED

Total number of applications received---------- 460

Age grouping of applicants:

1 year to 20 years	36
21 years to 40 years	178
41 years and over	245

Type of service requested:

Dialysis (in-center and home)	328
Transplant	65
Disposable supplies	126
Other services (post transplant, transportation costs, water bills, etc.)	149

Veterans---------- 48

Sex---------- Male--255 Female-- 205

Race---------- White--315 Black--128 Other-- 6

Medicare coverage--- Part A--271 Part B-- 255

Applied for Medicare Chronic Renal Disease Coverage----- 385

Medicaid recipient at this time---------- 131

Private health insurance coverage---------- 263

PROGRAM BUDGET AND EXPENDITURES

Appropriation Description

"25. For the establishment of the Kidney Health Care Division in the Texas Department of Health to provide care and treatment of persons suffering from chronic kidney diseases, including salaries and wages, travel expense, rent, capital outlay, professional and contract services and all other necessary activities for which no other provisions are made." $2,505,000.00

	BUDGET FOR YEAR	EXPENDED	UNEXPENDED BALANCE
Classified Salaries	$ 59,264.00	$19,078.00	$ 40,186.00
Professional Services	2,430,964.00	54,528.22	2,376,435.78
Travel Expenses	3,520.00	115.56	3,404.44
General Operating Expenses	2,578.00	102.19	2,475.81
Rental of Equipment	480.00	-0-	480.00
Rent	3,570.00	498.10	3,071.90
Inventoried Equipment	4,500.00	4,303.28	196.72
Grand Total	$2,504,876.00	$78,625.35	$2,426,250.65

CUMULATIVE STATISTICS ON PROGRAM RECIPIENT EXPENDITURES

Kidney Health Care patient claims processed----- 73

Funds expended---------- $49,581.22

Patients receiving benefits---------- 56

Patients reimbursed---------- 15 Amount---- $1,630.25

Medical facilities receiving payment---------- 4 Amount---- $43,474.19

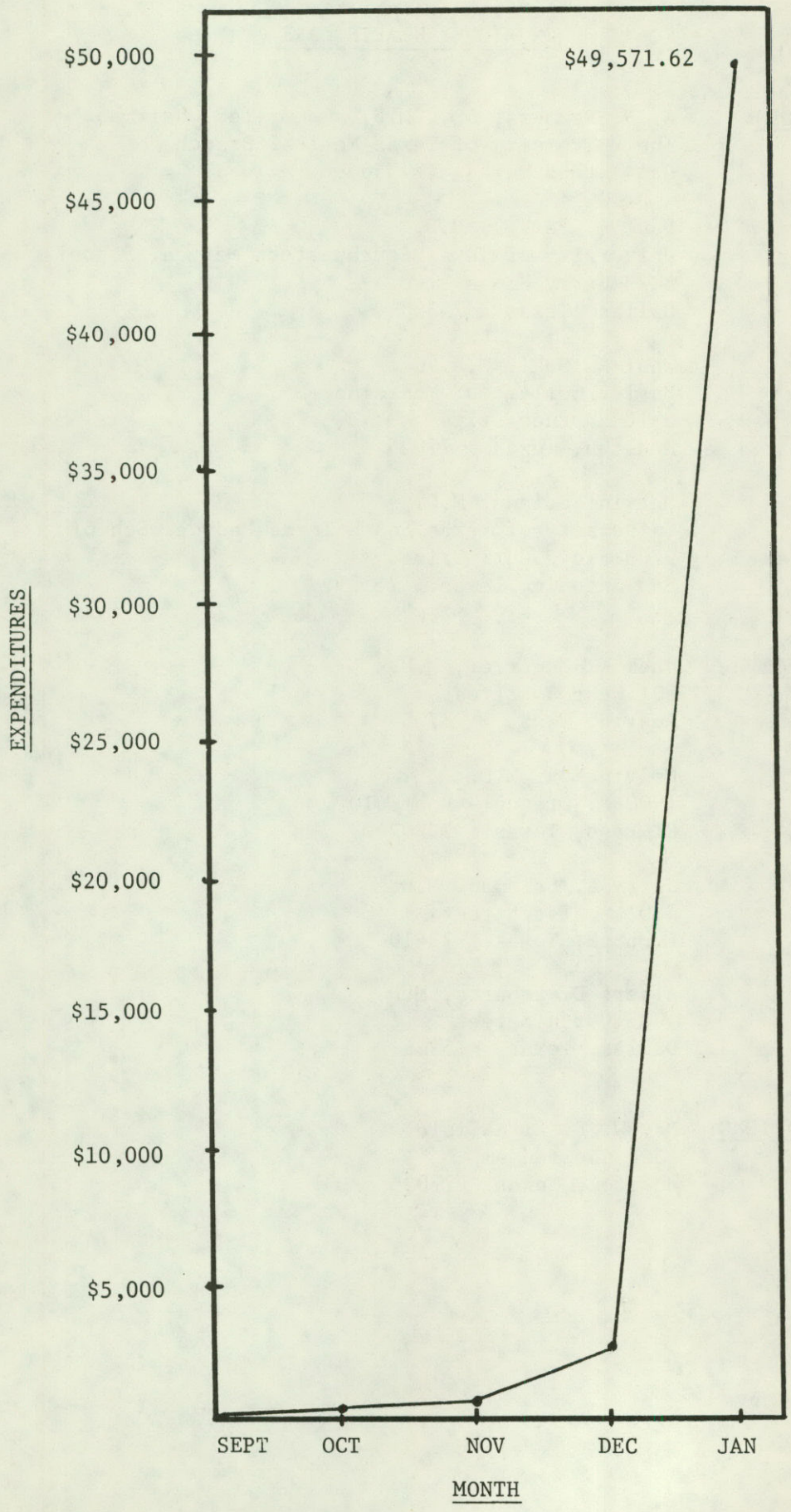
Pharmacies receiving payment---------- 13 Amount---- $2,413.24

Suppliers receiving payment---------- 2 Amount---- $487.04

Physicians receiving payment---------- 7 Amount---- $1,576.50

CUMULATIVE EXPENDITURES IN BEHALF OF

PROGRAM RECIPIENTS



STATE ADVISORY COMMITTEE

ON KIDNEY HEALTH CARE

MEDICAL SCHOOLS:

A. R. Remmers, Jr., M.D., Committee Chairman
The University of Texas Medical Branch
Galveston, Texas 77550

Paul C. Peters, M.D.
University of Texas Southwestern Medical School
5323 Harry Hines Blvd.
Dallas, Texas 75235

Wadi N. Suki, M.D.
Baylor College of Medicine
6516 Bertner Drive
Houston, Texas 77025

Marvin Forland, M.D.
University of Texas South Texas Medical School
7703 Floyd Curl Drive
San Antonio, Texas 78229

PRIVATE SECTOR:

Jack W. Moncrief, M.D.
801 West 34 Street
Austin, Texas 78705

Melvin Fox, M.D.
1900 N. Oregon - Room 410
El Paso, Texas 79902

Jerry A. Stirman, M.D.
3801 - 21st Street
Lubbock, Texas 79410

Albert D. Roberts, M.D.
4005 Worth Street
Dallas, Texas 75246

KIDNEY FOUNDATIONS:

Mr. W. E. Litchfield
5502 Cheltenham
Houston, Texas 77035

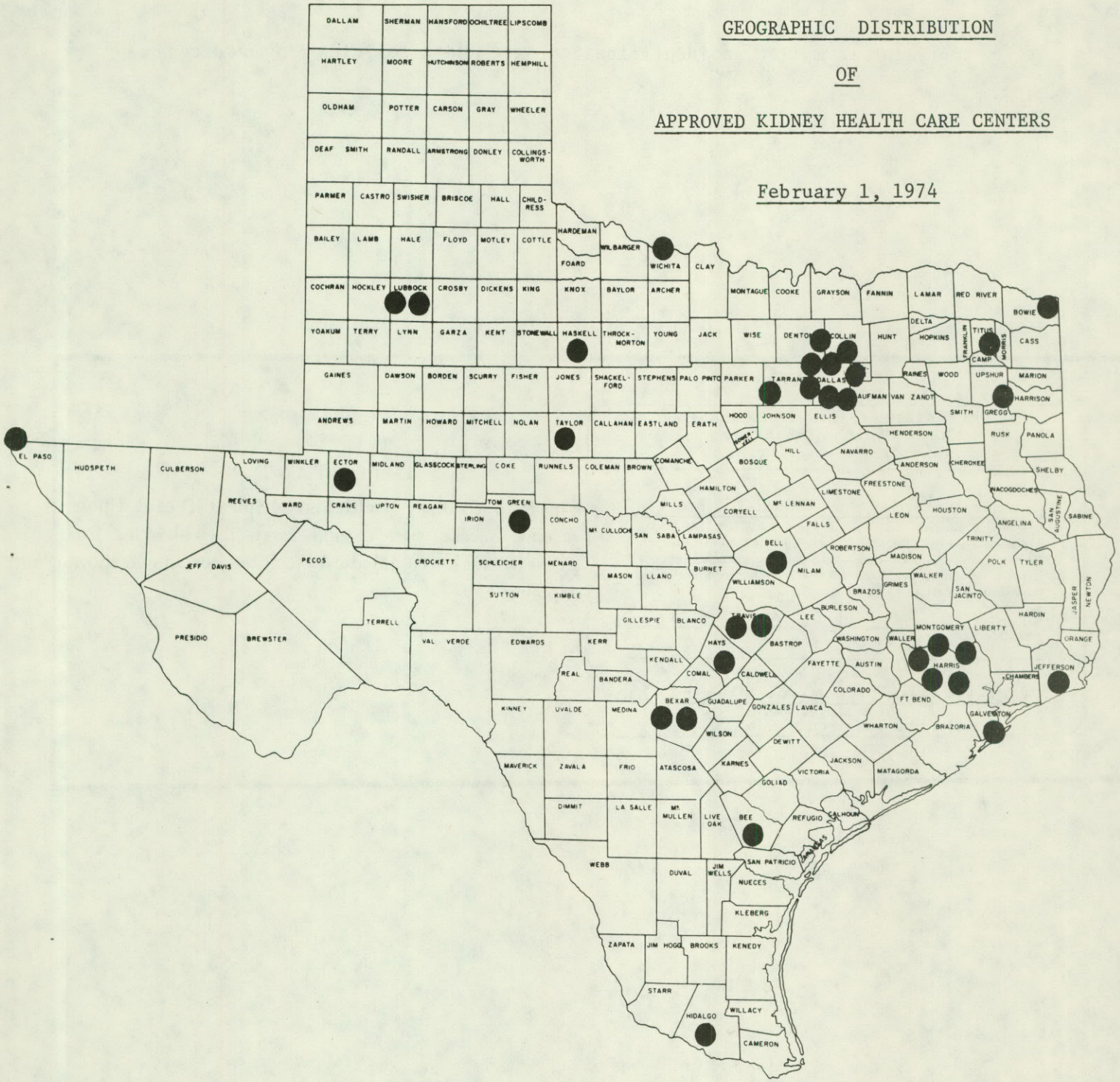
EXHIBIT 2

GEOGRAPHIC DISTRIBUTION

OF

APPROVED KIDNEY HEALTH CARE CENTERS

February 1, 1974



FORM NO. AG-6 (1969)

EXHIBIT 3

KIDNEY HEALTH CARE RECIPIENT

IDENTIFICATION CARD

Applicant is mailed an identification card and a Policies & Procedures booklet at the time of approval.

TEXAS STATE DEPARTMENT OF HEALTH
KIDNEY HEALTH CARE DIVISION

_____
Name

_____
Social Security No. K.H.C. No.
has been accepted for limited care and treatment under the Texas Kidney Health Care Act. Certain medical expenses relevant to chronic kidney disease may be paid under the provisions of Article 4477-20 V.A.C.S.

Issued: _____ Expires: August 31, 1975

_____
Signature of Patient or Guardian

Philip W. Mallory M.D.
Philip W. Mallory, M.D.,
Deputy Commissioner for Program Planning

IMPORTANT

This is your Kidney Health Care recipient ID card. Upon receipt, please sign it and carry it with you for presentation to Medical facilities or medication suppliers.

EXHIBIT 4

TEXAS STATE DEPARTMENT OF HEALTH

KIDNEY HEALTH CARE DIVISION

Policies and Procedures
Relating To
The Texas Kidney Health Care Act

September 11, 1973

TEXAS STATE DEPARTMENT OF HEALTH

KIDNEY HEALTH CARE DIVISION

TABLE OF CONTENTS

TEXAS STATE DEPARTMENT OF HEALTH
KIDNEY HEALTH CARE DIVISION

RULES AND REGULATIONS

September 1, 1973

The Kidney Health Care Division has as its primary purpose to provide for the cost of care and treatment of citizens of Texas who are suffering from chronic kidney disease.

The law under which it exists is The Kidney Health Care Act (Article 4477-20, VCS) which was passed by the 63rd Legislature. Activities outlined under this broad and comprehensive law are refined and restricted during the current biennium to the "care and treatment of patients" as stipulated in the appropriations bill which provides funds for this activity.

This program will function in accordance with the following RULES AND REGULATIONS as adopted by the Board of Health on September 9, 1973:

1. ELIGIBILITY

   A. Patient must be a citizen of Texas

   B. Patient must be diagnosed as having chronic kidney disease and be a candidate for dialysis or transplant.

2. ENTRY INTO PROGRAM

   A. Patient must be approved for care and treatment in Texas at one of the medical facilities which meet the Chronic Renal Disease Program requirements under Medicare and must receive treatment from such facilities.

   B. Application must be completed and sent to the Texas State Department of Health, Kidney Health Care Division, 1100 West 49th, Austin, Texas 78756. Notice of approval or disapproval will be made by this Division. Financial responsibility will begin on date of approval.

3. PAYMENT FOR SERVICES

The Kidney Health Care Division will pay for the following services to the extent that they are not covered by a Federal program, other State program, or a third party insurer.

A. Payment for dialysis, including the establishment of arterio-venous fistula and shunts, and tissue typing of patients and potential donors, but not to exclude other medically necessary treatments of chronic kidney disease.

B. The State will utilize the fee schedule as determined by Medicare as a basis for payment.

C. Payment for training for home dialysis.

D. Payment for expendable supplies, medications, blood, and medical treatment directly related to home dialysis. Payment to provide for qualified home aides when the requirement for their assistance is determined to be necessary by the facility medical review board for the care and treatment of chronic disease patients.

E. Payment for kidney transplantation, including cost of kidney procurement from donors or cadavers.

4. GENERAL PROVISIONS

A. Acceptance into the program carries an obligation by the patient to reimburse the State for a portion of the benefits received in accordance with Section 9 of the Kidney Health Care Act (Article 4477-20, VCS).

B. Prior to Medicare eligibility and in the event that the patient is not eligible for Medicare coverage, the Kidney Health Care Division will pay 100% of costs for kidney dialysis and transplants. After Medicare coverage starts, the Kidney Health Care Division will pay the 20% not covered by Medicare less any private insurance or benefits from other sources.

C. This program is designed to supplement private insurance and other health benefits programs, including Medicare, for which the patient might be eligible, and it is further stipulated that all program applicants will also make application to the Federal Medicare Program as early as possible.

D. The Kidney Health Care Division will not be responsible for payments until an application has been received and the care and treatment authorized.

E. Participating medical facilities will furnish the Kidney Health Care Division with a copy for each patient of the Medicare Chronic Renal Disease Patient History, Form SSA-2742, which they provide to the Medicare program.

F. Payees shall submit billing for their services on the State of Texas Purchase Voucher, Form 6-1.01. Itemization may be shown on the face of this form or the normal invoice form of the facility, showing this same itemization, may be attached to the State of Texas Purchase Voucher. The Vendor Certification in the lower left corner of this voucher must be completed. These prescribed forms will be furnished to the medical facilities and other payees by the State Department of Health.

G. Requests for payment for services provided patients under the sponsorship of the Kidney Health Care Division should be mailed directly to the Texas State Department of Health, Kidney Health Care Division, 1100 West 49th, Austin, Texas 78756.

TEXAS STATE DEPARTMENT OF HEALTH
KIDNEY HEALTH CARE DIVISION

LEGAL INTERPRETATION
of
SECTION 9, KIDNEY HEALTH CARE ACT
(S.B. 386, 63rd Leg.; Art. 4477-20, V.A.C.S.)

The following constitutes an interpretation of Sec. 9 of the Kidney Health Care Act (S.B. 386, 63rd Leg.; Art. 4477-20, V.A.C.S.); dealing with reimbursement to the State of Texas for the cost of care and/or treatment and the liability for such costs:

Section 9 deals with reimbursement to the State of Texas for the cost of kidney care treatment when the State has paid for such treatment or has become obligated for such payment. While the section does not set an actual dollar amount, it provides that the lesser of the following two amounts shall be paid: full reimbursement of all funds expended in a case or insurance proceeds which are paid to the insured by the insurance company by reason of liability for the payment of the cost of treatment plus five percent of the adjusted gross income of the patient (or other liable person) less the amount of premium paid by the patient for the above mentioned insurance policy.

Two examples follow:

1. Suppose the State expended (or obligated itself to expend) $5,000.00 in a particular case. Suppose also this patient carried an insurance policy in the amount of $10,000.00 which covered this treatment. The State would then collect $5,000.00 on the insurance policy and that would be full reimbursement.

2. Suppose the insured carried a $5,000.00 policy and his gross adjusted income was $10,000.00 per year. Further, this patient paid $100.00 annually in premiums for the insurance. The State expends $10,000.00 in this particular example. Payment would then be made by collection of the full face amount of the policy ($5,000.00) plus $400.00 from the patient, this latter amount representing five percent of his gross adjusted income less the $100.00 paid for the insurance premium. This is the maximum amount for which this person can be held liable regardless of the fact that the State expended an amount greater than this in his case.

If the patient has no insurance, then his liability would simply be five percent of his adjusted gross income for the year.

If payment is made directly to the medical provider by an insurance company under a plan or policy held by the patient, this is in no way affected by the foregoing because in this case the State would not expend any funds or be liable for such expenditure and, therefore, no reimbursement would be in order.

TEXAS STATE DEPARTMENT OF HEALTH
KIDNEY HEALTH CARE DIVISION

INSTRUCTIONS FOR COMPLETING
APPLICATION KIDNEY HEALTH CARE FORM KHC 1

Patient Information

Item 1-12 — Information requested is self explanatory. Each blank should be completed especially the name of the hospital and address; and the physician and his address. If the patient is a minor, then include the name of the parent or guardian and his social security number, too.

Type of Treatment or Service

Item 13 — Dialysis—check if patient is a candidate for dialysis or receiving dialysis treatments in a facility or at home.

Item 14 — Transplant—check if patient is a candidate for transplant or has already received a transplant. In some cases Items 13 and 14 will be checked if a patient is on dialysis and a candidate for transplant.

Item 15 — Disposable supplies—check if supplies are needed for home dialysis.

Item 16 — Other Services—check if none of the other items in this section meet the needs of the patient. Briefly describe the type of service requested and the approximate costs.

Physician Certification

Item 17 — The physician signature and date signed must be completed in order for the application to be approved.

Medical Information

Item 18 — S.S.A. Form 2742—check yes or no if this form is attached to the application. A copy of the original form is required but in some cases it may not be available at the time. If this is the case then note the circumstances in the appropriate blanks. Before any payments can be made for the patient, this form will have to be completed and sent in.

Insurance Information

Item 22-23 — Medicare Health Insurance—check yes or no for Part A, and yes or no for Part B. If yes, give the claim number. If claim number has not been assigned, leave item 23 blank and notify the Health Department later when a claim number has been assigned.

Item 24 — If you answered no to Item 22, then indicate whether or not you have applied for Chronic Renal Disease benefits under Medicare.

Item 25-26 — Medicaid Recipient—check yes or no, and if yes give the case number in item 25.

Patient Authorization Statement

Item 27 — The patient must sign and date the application. In the case of a minor, then the parent or guardian should sign and indicate relationship to the patient.

Return completed application to:

Texas State Department of Health
Kidney Health Care Division
1100 West 49th Street
Austin, Texas 78756

TEXAS STATE DEPARTMENT OF HEALTH
KIDNEY HEALTH CARE DIVISION
APPLICATION FOR BENEFITS UNDER PROVISIONS OF ART. 4477-20 V.A.C.S., KIDNEY HEALTH CARE ACT

K.H.C. No. _____

Date Rcvd. _____

Date Approved _____

Approved by _____

HEALTH DEPT. USE ONLY

PATIENT INFORMATION

1. Patient's Name _____ (last / first / middle) 2. Social Security No. _____

3. Date of Birth _____ (mo. / day / yr.) 4. Citizen of U.S. ☐ yes ☐ no 5. How long have you lived in Texas? _____

6. Permanent Home Address _____ (street / city / zip code) Phone No. _____

7. Veteran ☐ yes ☐ no 8. Sex ☐ female ☐ male 9. Race _____ 10. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

11. Name of Hospital or Clinic _____

Address _____ (street / city / zip code)

12. Name of Physician _____

Address _____ (street / city / zip code)

TYPE OF TREATMENT OR SERVICE

13. ☐ Dialysis 14. ☐ Transplant 15. ☐ Disposable Supplies

16. ☐ Other services provided for in program guidelines. Specify service and estimate of cost.

_____

_____

_____

_____

PHYSICIAN CERTIFICATION

17. This is to certify that I have examined the above patient and found the presence of a chronic, irreversible kidney disease.

_____ (Signature of physician) _____ (Date)

MEDICAL INFORMATION

18. SSA Form 2742 attached ☐ yes ☐ no This application cannot be approved unless accompanied by a copy of the **MEDICARE CHRONIC RENAL DISEASE PATIENT HISTORY Form SSA-2742.** (These forms are available from the hospital or clinic named in Item.11.) If not included with the application at this time, please explain. _____

_____

_____

INSURANCE INFORMATION

19. Do you have private health insurance? ☐ yes ☐ no

20. If, yes indicate type of coverage. ☐ MEDICAL ☐ HOSPITAL ☐ MAJOR MEDICAL

21.

Name of Insurance Co.	Address	Policy No.	Policy holder

22. Are you currently enrolled in Medicare Health Insurance? Part A ☐ yes ☐ no Part B ☐ yes ☐ no

23. If yes, claim no. _____

24. If no, have you applied for benefits under the Medicare Chronic Renal Disease Program? ☐ yes ☐ no

25. Are you a Medicaid recipient? ☐ yes ☐ no 26. If yes, case no. _____

PATIENT AUTHORIZATION STATEMENT

27. The above eligibility information is correct to the best of my knowledge and the agency to which I am applying for benefits has my permission to further investigate my eligibility.

I understand that personal information will be held confidential by the agency providing service and authorize the request for and release of such information as is necessary for the purpose of providing assistance.

I further authorize the Social Security Administration to release to the Texas State Department of Health any information concerning my entitlement to Medicare coverage and Medicare benefits payable to me or on my behalf that is necessary for processing claims under the Texas Kidney Health Care Act. I agree to comply with the Kidney Health Care Division's rules and regulations as promulgated by the State Board of Health.

_____ Signature of Applicant

_____ Date

This service is rendered in compliance with Title VI, Civil Rights Act, 1964.

Comptroller's Voucher No.	Fund No.	Dept. No.	Appropriation No.
		501	
		501	
		501	

Form 6-1.01
Rev. 8-71
Art. 4344b R.C.S.

STATE OF TEXAS
PURCHASE VOUCHER
(For Purchases and Services other than Personal)

AMOUNT

1 Pay to (Physician or Facility)

Social Security Number or Tax ID Number

2 Address P.O. Box 981 (Street) Lubbock (City) Texas (State) 78125 (Zip Code)

Payees References Date

Expenditure Account No.		
Comptroller's		Departmental
Account No.	Amount	Budget
		Fund

State Agency: TEXAS STATE DEPARTMENT OF HEALTH
Austin, Texas 78756

Board of Control Order No. | Date of Order | Requisition Number

Departmental Voucher No.

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	QUANTITY	UNIT PRICE	AMOUNT
	3 Class _____ Item _____ Care and Treatment of persons suffering from Chronic Kidney Diseases:			
9/3-9/30/73	4 John Doe, 453-06-2948 Hemodialysis, Chronic-Home Training			$ 1900.00
	LESS: Medicare Payment			1520.00
	Private Insurance Payment			200.00
				180.00
9/30/73	5 Mary Smith, 464-02-3456 "As Per Billing Attached."			$ 500.00
	LESS: Medicare Payment			400.00
	Private Insurance Payment			50.00
				50.00
	6 I, the undersigned, do certify that these charges are the same as those allowed for like procedures/services under the approved fee schedule for Medicare payments.			
	8 Cash Discount _____%		7	$ 230.00

VENDOR CERTIFICATION or AFFIDAVIT WHEN REQUIRED BY LAW
CERTIFICATION

I, Joe Jones do hereby certify that I am Insurance Clerk
(Title of person certifying)
and that I am duly authorized to make this certification for and on behalf of (Physician or Facility)
(Name of payee company/claimant)
I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct, and unpaid.

9 Joe Jones
(Signature)

AFFIDAVIT

Sworn to before me this _____ day of _____ 19____

Notary Public _____
County State

Agency Certification—
I certify that the above services were rendered, or goods received; and that they correspond in every particular with the contract under which they were procured and that the invoice is true and unpaid.

Budget _____ Category _____ Fund _____

DIRECTOR
Name

PURCHASING
Name

Date Approved for Payment _____ 19____

APPROVED FOR PAYMENT BY FISCAL OFFICE:

Name

PRICES ABOVE ARE APPROVED

By _____
Board of Control

FORM NO. AG—37 (1971)

INSTRUCTIONS TO PHYSICIANS OR FACILITIES FOR COMPLETING
STATE OF TEXAS PURCHASE VOUCHER

Please read the following instructions before completing the Voucher. To avoid delay in processing of the claim, the voucher must contain the information as requested in the instructions.

CLAIMS TO THE STATE SHOULD BE MADE ONLY AFTER ALL OTHER THIRD PARTY COVERAGE HAS BEEN MET.

Patients covered by Medicare - a copy of the "Explanation of Medicare Payments" must be attached to the Purchase Voucher.

Patients not covered by Medicare - So state on the voucher.

Patients covered by private insurance - submit copy of the payment explanation.

1. Pay to - name of physician or facility providing service to patient.

2. Address - Complete mailing address of Physician or facility.

3. The statement "Care and Treatment of persons suffering from Chronic kidney disease:" must be on the purchase voucher in order to be processed.

4. Patients name, social security number and date and charge amount for each service performed. The full amount for charges must be listed, and Medicare payments and private insurance payments deducted in the amount column.

5. The same information is requested as in item 4, if an itemized invoice is attached, use the phrase "As per billing attached."

6. The following statement must appear on the face of the voucher: "I, the undersigned, do certify that these charges are the same as those allowed for like procedures/services under the approved fee schedule for Medicare payments."

7. Total amount due on the purchase voucher submitted.

8. Vendor Certification - complete certification only.

9. Signature of the individual named in Item 8. (Signature does not have to be notarized.)

Mail all five copies to: Texas State Department of Health
Kidney Health Care Division
1100 West 49th Street
Austin, Texas 78756

A copy will be returned to you with a State of Texas Treasury Warrant. Normal processing of payments requires two or three weeks.

Comptroller's Voucher No.	Fund No.	Dept. No.	Appropriation No.
		501	
		501	
		501	

Form 6-1.01
Rev. 8-71
Art. 4344b R.C.S.

STATE OF TEXAS
PURCHASE VOUCHER
(For Purchases and Services other than Personal)

AMOUNT

1

Pay to Supplier

2

Expenditure Account No.

Comptroller's Account No.	Amount	Departmental Budget
		Fund

Address P.O. Box 5928 (Street) Austin (City) Texas (State) 78701 (Zip Code)

Payees References _____ Date _____

State Agency: TEXAS STATE DEPARTMENT OF HEALTH, Austin, Texas 78756

Board of Control Order No. _____ Date of Order _____ Requisition Number _____

Departmental Voucher No. _____

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	QUANTITY	UNIT PRICE	AMOUNT
	3 Class _____ Item _____ For the care and treatment of persons suffering from Chronic Kidney Diseases:			
7/1-9/30/73	4 John Doe, 453-06-2948 Water Deionization Service	360 gals	.10	$ 36.00
	Less Medicare 80% (if applicable)			28.00
	Total Due			8.00
9/30/73	5 Mary Smith, 464-02-2948 Disposable Dialysis Supplies as per attached invoice			$ 500.00
	Less Medicare 80% (if applicable)			400.00
	Total Due			100.00
	6 I, the undersigned, do certify that these charges are the same as those allowed for like supplies/ services under the approved payment schedule for Medicare payments.			
	8 Cash Discount _____ %		7	$ 108.00

VENDOR CERTIFICATION or AFFIDAVIT WHEN REQUIRED BY LAW
CERTIFICATION

I, Mary Jones do hereby certify that I am Bookkeeper (Title of person certifying) and that I am duly authorized to make this certification for and on behalf of Discount Pharmacy (Name of payee company/claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct, and unpaid.

9 Mary Jones (Signature)

AFFIDAVIT

Sworn to before me this _____ day of _____ 19____

Notary Public _____
County State

FORM NO. AG-37 (1971)

Agency Certification—
I certify that the above services were rendered, or goods received; and that they correspond in every particular with the contract under which they were procured and that the invoice is true and unpaid.

Budget _____ Category _____ Fund _____

_____ DIRECTOR
Name

_____ PURCHASING
Name

Date Approved for Payment _____ 19____

APPROVED FOR PAYMENT BY FISCAL OFFICE:

_____
Name

PRICES ABOVE ARE APPROVED

By _____
Board of Control

INSTRUCTIONS TO SUPPLIER FOR COMPLETING STATE OF TEXAS PURCHASE VOUCHER

Please read the following instructions before completing the Voucher. To avoid delay in processing of the claim, the voucher must contain the information as requested in the instructions.

1. Name of Supplier - print or type the name.

2. Mailing Address - print or type complete mailing address.

3. Statement - Itemized billing should be preceded by the following statement: For the care and treatment of persons suffering from chronic kidney disease.

4. Name of the customer and their Social Security Number. In date column give dates services were provided, and beneath the name of the customer list services provided. Complete quantity, unit price and amount columns for each service. Show Medicare payment, and if not applicable write N/A. Show total amount due as per sample on the front of this Purchase Voucher.

5. This can be another customer if you wish to list more than one on a Purchase Voucher. Be sure to furnish complete information on the individual as requested in Item 4 above.

6. The statement "I, the undersigned, do certify that these charges are the same as those allowed for like supplies/services under the approved payment schedule for Medicare payments." - must be on the Purchase Voucher in order to be processed.

7. This item should show the total amount requested on the Purchase Voucher.

8. Vendor Certification needs to be completed as shown on sample voucher.

9. Signature of the above named person in item 9 is required before the voucher can be processed. IT IS NOT NECESSARY FOR THIS SIGNATURE TO BE NOTARIZED.

Send completed Purchase Voucher to:

Texas State Department of Health
Kidney Health Care Division
1100 West 49th Street
Austin, Texas 78756

Comptroller's Voucher No.	Fund No.	Dept. No.	Appropriation No.
		501	
		501	
		501	

Form 6-1.01
Rev. 8-71
Art. 4344b R.C.S.

STATE OF TEXAS
PURCHASE VOUCHER
(For Purchases and Services other than Personal)

AMOUNT

1

Pay to Pharmacy

Expenditure Account No.		
Comptroller's		Departmental
Account No.	Amount	Budget
		Fund

2

Address P.O. Box 5928 (Street) Austin (City) Texas (State) 78701 (Zip Code)

Payees References _____ Date _____

State Agency: TEXAS STATE DEPARTMENT OF HEALTH, Austin, Texas 78756

Board of Control Order No. _____ Date of Order _____ Requisition Number _____

Departmental Voucher No. _____

DELIVERY DATE	DESCRIPTION OF ARTICLES OR SERVICES	QUANTITY	UNIT PRICE	AMOUNT
	3 Class _____ Item _____ For the Care and Treatment of persons suffering from Chronic Kidney Diseases:			
9/30/73	4 Jane Jones, 465-01-6543			
	5 Rx #2609 - (Name of Drug)	1 ea	7.50	$ 7.50
	6 Non-Legend items as per attached invoice			50.00
				57.50
	7 I, the undersigned, do certify that these charges are the same as those allowed for like supplies/ services under the approved payment schedule for Medicaid payments.			
	9 Cash Discount _____ %		8	$ 57.50

VENDOR CERTIFICATION or AFFIDAVIT WHEN REQUIRED BY LAW
CERTIFICATION

I, Mary Jones do hereby certify that I am Bookkeeper (Title of person certifying) and that I am duly authorized to make this certification for and on behalf of ABC Pharmacy (Name of payee company/claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct, and unpaid.

10 Mary Jones (Signature)

AFFIDAVIT

Sworn to before me this _____ day of _____ 19__

Notary Public _____ County _____ State _____

Agency Certification—
I certify that the above services were rendered, or goods received and that they correspond in every particular with the contract under which they were procured and that the invoice is true and unpaid.

Budget _____ Category _____ Fund _____

DIRECTOR
Name

PURCHASING
Name

Date Approved for Payment _____ 19__

APPROVED FOR PAYMENT BY FISCAL OFFICE:

Name

PRICES ABOVE ARE APPROVED

By _____
Board of Control

FORM NO. AG—37 (1971)

INSTRUCTIONS TO PHARMACIES FOR COMPLETING
STATE OF TEXAS PURCHASE VOUCHER

Please read the following instructions before completing the Voucher. To avoid delay in processing of the claim, the voucher must contain the information as requested in the instructions.

1. Please print or type the name of the Pharmacy.

2. Please print or type the complete mailing address of the Pharmacy.

3. Itemized billing should be preceded by the following statement: "For the care and treatment of persons suffering from chronic kidney disease."

4. The name of your customer who has been approved for participation in the State Kidney Health Care Program. Include this person's Social Security Number and date supplies purchased.

5. Prescriptions should be identified by Rx number, and the name and strength of the drug should be noted. The quantity, unit price and amount should be completed for each Rx item.

6. **Medically required non-legend items should be identified by name. The quantity, unit price, and amount should be completed for each non-legend item. Invoices must be attached supporting this amount.**

7. The statement "I, the undersigned, do certify that these charges are the same as those allowed for like supplies/services under the approved payment schedule for Medicaid payments." - must appear on the Purchase Voucher.

8. Total the amounts in the amount column. This will be the amount the Pharmacy wants to be reimbursed by the State.

9. Type in name of the representative for the Pharmacy who is authorized to complete the P-1. Complete, as per sample.

10. Signature of above named individual in Item 9 is required before the voucher can be processed. IT IS NOT NECESSARY FOR THIS SIGNATURE TO BE NOTARIZED.

Send completed Purchase Voucher to:

Texas State Department of Health
Kidney Health Care Division
1100 West 49th Street
Austin, Texas 78756

APPROVED KIDNEY HEALTH CARE FACILITIES
February 1, 1974

CITY AND NAME OF FACILITY	TYPE FACILITY		TYPE SERVICE	
	Hospital	Limited Care Facility	Transplant and Dialysis	Maintenance Dialysis
ABILENE				
Hendrick Memorial Hospital	X			X
AUSTIN				
Brackenridge Hospital	X		X	
Austin Diagnostic Clinic		X		X
BEEVILLE				
Memorial Hospital	X			X
DALLAS				
Dallas County Hospital District	X		X	
Dallas Osteopathic Hospital	X			X
Baylor Medical Center	X			X
Southwestern Dialysis Center		X		X
Dallas Kidney Disease Center (Bristol General Hospital)		X		X
Methodist Hospital of Dallas	X			X
Children's Medical Center	X			X
EL PASO				
Hotel Dieu Hospital	X			X
FORT WORTH				
Dialysis Associates (Tarrent Co. Nephrology Center)		X		X
GALVESTON				
Univ of Texas Medical Branch	X		X	
HASKELL				
Haskell Memorial Hospital	X			X
HOUSTON				
Methodist Hospital (Community Dialysis Center)	X		X	
Harris County Hospital District	X		X	
Hermann Hospital	X			X
St. Joseph Hospital	X			X
Gulf Coast Dialysis Center		X		X

CITY AND NAME OF FACILITY	TYPE FACILITY		TYPE SERVICE	
	Hospital	Limited Care Facility	Transplant and Dialysis	Maintenance Dialysis
LONGVIEW				
Good Shepherd Hospital----------	X			X
LUBBOCK				
Methodist Hospital----------	X			X
South Plains Dialysis Center------		X		X
MC ALLEN				
McAllen General Hospital----------	X			X
NAPLES				
David Granberry Memorial Hospital--	X			X
ODESSA				
Medical Center Hospital----------	X			X
PORT ARTHUR				
St. Mary's Hospital----------	X			X
SAN ANGELO				
St. Johns Hospital----------	X			X
SAN ANTONIO				
Bexar County Hospital District----	X		X	
Baptist Hospital----------	X			X
Santa Rosa Medical Center---------	X			X
SAN MARCOS				
Hays Memorial Hospital----------	X			X
TEMPLE				
Scott and White Clinic----------		X		X
TEXARKANA				
Wadley Hospital----------	X			X
WICHITA FALLS				
Wichita General Hospital----------	X			X