

FRONT SIDE



**DATA CONTROL SECTION
SMIB ANALYSIS & CORRECTIONS UNIT**

DATE: _____

TO: SOCIAL SECURITY ADMINISTRATION

DOC: _____

SUBJECT: **ESRD** MEDICARE ENTITLEMENT ON

NAME: _____ PCN: _____

ADDRESS: _____

SSN: _____ SSCN: _____ DOB: _____

DIALYSIS START DATE: _____ ALIEN DATE ON SSR: _____

The Department of Human Services has information indicating the above-named person is potentially eligible for Medicare enrollment due to end-stage renal disease. Please complete this form and return it to the address shown below.

Fold along this line and place with address below showing in a window envelope

ATTN:

**TEXAS DEPARTMENT OF HUMAN SERVICES
DATA CONTROL SECTION
SMIB ANALYSIS & CONTROL UNIT, Y-922
P.O. BOX 149030
AUSTIN, TEXAS 78714-9030**

FORM 7376 / 08-2003

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