U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED: OMB NO. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS

1. Name *(Last, First, Middle Initial)*

2. Health Insurance Claim Number

3. Social Security Number

4. Full Address *(Include City, State, and Zip)*

5. Phone Number
( )

6. Date of Birth
_____/_____/_____
MM DD YYYY

7. Sex
☐ Male ☐ Female

8. Ethnicity
☐ Hispanic: Mexican ☐ Hispanic: Other ☐ Non-Hispanic

9. Race *(Check **one** box only)*
☐ White
☐ Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Pacific Islander
☐ Mid-East/Arabian
☐ Indian sub-Continent
☐ Other, specify _____
☐ Unknown

10. Medical Coverage *(Check **all** that apply)*
a. ☐ Medicaid
b. ☐ DVA
c. ☐ Medicare
d. ☐ Employer Group Health Insurance
e. ☐ Other Medical Insurance
f. ☐ None

11. Is Patient Applying for ESRD Medicare Coverage? *(if **YES**, enter address of social security office)*
☐ Yes ☐ No

ADDRESS

CITY STATE ZIP

12. Primary Cause of Renal Failure *(Use code from back of form)*

13. Height
INCHES **OR** CENTIMETERS

14. Dry Weight
POUNDS **OR** KILOGRAMS

15. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

16. Co-Morbid Conditions *(Check **ALL** that apply currently or during last 10 years)* *See instructions
a. ☐ Congestive heart failure
b. ☐ Ischemic heart disease, CAD*
c. ☐ Myocardial infarction
d. ☐ Cardiac arrest
e. ☐ Cardiac dysrhythmia
f. ☐ Pericarditis
g. ☐ Cerebrovascular disease, CVA, TIA*
h. ☐ Peripheral vascular disease*
i. ☐ History of hypertension
j. ☐ Diabetes (primary or contributing)
k. ☐ Diabetes, currently on insulin
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Alcohol dependence
p. ☐ Drug dependence*
q. ☐ HIV positive status ☐ Can't Disclose
r. ☐ AIDS ☐ Can't Disclose
s. ☐ Inability to ambulate
t. ☐ Inability to transfer

17. Was pre-dialysis/transplant EPO administered?
☐ Yes ☐ No

18. Laboratory Values Prior to First Dialysis Treatment or Transplant *See Instructions.

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Hematocrit (%)			e. Serum Creatinine (mg/dl)		
b. Hemoglobin (g/dl)*			f. Creatinine Clearance (ml/min)*		
c. Serum Albumin (g/dl)			g. BUN (mg/dl)*		
d. Serum Albumin Lower Limit (g/dl)			h. Urea Clearance (ml/min)*		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT.

19. Name of Provider

20. Medicare Provider Number

21. Primary Dialysis Setting
☐ Hospital Inpatient ☐ Dialysis Facility/Center ☐ Home

22. Primary Type of Dialysis
☐ Hemodialysis ☐ IPD ☐ CAPD ☐ CCPD ☐ Other

23. Date Regular Dialysis Began
_____/_____/_____
MM DD YY

24. Date Patient Started Chronic Dialysis at Current Facility
_____/_____/_____
MM DD YY

25. Date Dialysis Stopped
_____/_____/_____
MM DD YY

26. Date of Death
_____/_____/_____
MM DD YY

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant	28. Name of Transplant Hospital	29. Medicare Provider Number for Item 28
_____/_____/_____ MM DD YY		

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

30. Enter Date	31. Name of Preparation Hospital	32. Medicare Provider Number for Item 31
_____/_____/_____ MM DD YY		

33. Current Status of Transplant

☐ Functioning ☐ Non-Functioning

34. If Nonfunctioning, Date of Return To Regular Dialysis	35. Current Dialysis Treatment Site
_____/_____/_____ MM DD YY	☐ Hospital Inpatient ☐ Dialysis Facility/Center ☐ Home

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

36. Name of Training Provider	37. Medicare Provider Number of Training Provider

38. Date Training Began	39. Type of Training
_____/_____/_____ MM DD YY	☐ Hemodialysis ☐ IPD ☐ CAPD ☐ CCPD

40. This Patient is Expected to Complete *(or has completed)* Training and Will Self-dialyze on a Regular Basis.	41. Date When Patient Completed, or is Expected to Complete, Training
☐ Yes ☐ No	_____/_____/_____ MM DD YY

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

42. Printed Name and Signature of Physician personally familiar with the patient's training	43. UPIN of Physician in Item 42

E. PHYSICIAN IDENTIFICATION

44. Attending Physician *(Print)*	45. Physician's Phone No.	46. UPIN of Physician in Item 44
	( )	

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

47. Attending Physician's Signature of Attestation *(Same as Item 44.)*	48. Date
	_____/_____/_____ MM DD YY

49 . Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

50. Signature of Patient *(Signature by mark must be witnessed.)*	51. Date
	_____/_____/_____ MM DD YY

G. PRIVACY ACT STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Privacy Act Issuance, 1991 Compilation, Vol. 1, pages 436-437, December 31, 1991 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for a research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

H. FOR ESRD NETWORK USE ONLY IN CASES REFERRED TO ESRD MEDICAL REVIEW BOARD

52. Network Confirmed as ESRD	53. Authorized Signature	54. Date	55. Network Number
☐ Yes ☐ No		_____/_____/_____ MM DD YY	

LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE

Item 12. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-CM code plus the letter code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary.

ICD-9	LTR	NARRATIVE
DIABETES		
25000	A	Type II, adult-onset type or unspecified type diabetes
25001	A	Type I, juvenile type, ketosis prone diabetes
GLOMERULONEPHRITIS		
5829	A	Glomerulonephritis (GN) (histologically not examined)
5821	A	Focal glomerulosclerosis, focal sclerosing GN
5831	A	Membranous nephropathy
5832	A	Membranoproliferative GN type 1, diffuse MPGN
5832	C	Dense deposit disease, MPGN type 2
58381	B	IgA nephropathy, Berger's disease (proven by immunofluorescence)
58381	C	IgM nephropathy (proven by immunofluorescence)
5804	B	Rapidly progressive GN
5834	C	Goodpasture's Syndrome
5800	C	Post infectious GN, SBE
5820	A	Other proliferative GN
SECONDARY GN/VASCULITIS		
7100	E	Lupus erythematosus, (SLE nephritis)
2870	A	Henoch-Schonlein syndrome
7101	B	Scleroderma
2831	A	Hemolytic uremic syndrome
4460	C	Polyarteritis
4464	B	Wegener's granulomatosis
5839	C	Nephropathy due to heroin abuse and related drugs
4462	A	Vasculitis and its derivatives
5839	B	Secondary GN, other
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS		
9659	A	Analgesic abuse
5830	B	Radiation nephritis
9849	A	Lead nephropathy
5909	A	Nephropathy caused by other agents
27410	A	Gouty nephropathy
5920	C	Nephrolithiasis
5996	A	Acquired obstructive uropathy
5900	A	Chronic pyelonephritis, reflux nephropathy
58389	B	Chronic interstitial nephritis
58089	A	Acute interstitial nephritis
5929	B	Urolithiasis
2754	A	Nephrocalcinosis
HYPERTENSION/LARGE VESSEL DISEASE		
4039	D	Renal disease due to hypertension (no primary renal disease)
4401	A	Renal artery stenosis
59381	B	Renal artery occlusion
59381	E	Cholesterol emboli, renal emboli
CYSTIC/HEREDITARY/CONGENITAL DISEASES		
75313	A	Polycystic kidneys, adult type (dominant)
75314	A	Polycystic, infantile (recessive)
75316	A	Medullary cystic disease, including nephronophthisis
7595	A	Tuberous sclerosis
7598	A	Hereditary nephritis, Alport's syndrome
2700	A	Cystinosis
2718	B	Primary oxalosis
2727	A	Fabry's disease
7533	A	Congenital nephrotic syndrome
5839	D	Drash syndrome, mesangial sclerosis
7532	A	Congenital obstructive uropathy
7530	B	Renal hypoplasia, dysplasia, oligonephronia
7567	A	Prune belly syndrome
7598	B	Hereditary/familial nephropathy
NEOPLASMS/TUMORS		
1890	B	Renal tumor (malignant)
1899	A	Urinary tract tumor (malignant)
2230	A	Renal tumor (benign)
2239	A	Urinary tract tumor (benign)
2395	A	Renal tumor (unspecified)
2395	B	Urinary tract tumor (unspecified)
20280	A	Lymphoma of kidneys
2030	A	Multiple myeloma
2030	B	Light chain nephropathy
2773	A	Amyloidosis
99680	A	Complication post bone marrow or other transplant
MISCELLANEOUS CONDITIONS		
28260	A	Sickle cell disease/anemia
28269	A	Sickle cell trait and other sickle cell (HbS/Hb other)
64620	A	Post partum renal failure
0429	A	AIDS nephropathy
8660	A	Traumatic or surgical loss of kidney(s)
5724	A	Hepatorenal syndrome
5836	A	Tubular necrosis (no recovery)
59389	A	Other renal disorders
7999	A	Etiology uncertain

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form **SHOULD NOT** be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form **MUST BE** completed within 45 days for **ALL** patients beginning any of the following:

A. For all patients who initially receive a kidney transplant instead of a course of dialysis.
B. All patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient. This form should be completed for all patients in this category even if the patient dies within this time period.
C. For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.
D. For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare benefits.

All Items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease
Items 12, 16, 47-48: To be completed by the attending physician.
Item 42: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 50 and 51: To be signed and dated by the patient.

1 Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.

2 If the patient is covered by Medicare, enter his/her Health Insurance Claim Number as it appears on his/her Medicare card. This number can be verified from his/her Medicare card.

3 Enter the patient's own social security number. This number can be verified from his/her social security card.

4 Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)

5 Enter the patient's home area code and telephone number.

6 Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.

7 Check the appropriate block to identify sex.

8 Check the appropriate block to identify ethnicity. Definitions of the basic ethnicity categories for Federal statistics are as follows:

Hispanic: Mexican—A person of Mexican culture or origin, regardless of race.

Hispanic: Other—A person of Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Non-Hispanic—A person of culture or origin not described above, regardless of race.

9 Check **one** appropriate block to identify race. Definitions of the basic racial categories for Federal statistics are as follows:

White—A person having origins in any of the original white peoples of Europe.

Black—A person having origins in any of the black racial groups of Africa.

American Indian/Alaskan Native—A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Asian—A person having origins in any of the original peoples of the Far East and Southeast Asia. Examples of this area include China, Japan and Korea.

Pacific Islander—A person having origins in any of the peoples of the Pacific Islands. Examples of this area include the Philippine Islands, Samoa and Hawaiian Islands.

Mid-East/Arabian—A person having origins in any of the peoples of the Middle East and Northern Africa. Examples of this area include Egypt, Israel, Iran, Iraq, Saudi Arabia, Jordan, and Kuwait.

Indian Sub-Continent—A person having origins in any of the peoples of the Indian Sub-continent. Examples of this area include India and Pakistan.

Other, specify—A person not having origins in any of the above categories. Write race(s) in space provided.

Unknown—Check this block if race is unknown.

10 Check **all** the blocks that apply to this patient's current medical insurance status.

Medicare—Patient is currently entitled to Federal Medicare benefits.

Medicaid—Patient is currently receiving State Medicaid benefits.

DISTRIBUTION OF COPIES:

- Forward the first part (blue) of this form to the Social Security office servicing the claim.
- Forward the second (green) of this form to the ESRD Network Coordinating Council.
- Retain the last part (white) in the patient's medical records file.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Employer Group Health Insurance—Patient receives medical benefits through an employer group health plan that covers employees, former employees, or the families of employees or former employees.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

11 Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he should re-apply for ESRD Medicare coverage. If answer is yes, enter the address of the local Social Security office (street address, city, state and zip code) where patient will be applying for benefits.

12 **To be completed by the attending physician.** Enter the ICD-9-CM plus letter code from back of form to indicate the primary cause of end stage renal disease. These are the only acceptable causes of end stage renal disease.

13 Enter the patient's most recent recorded height in inches **OR** centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14 Enter the patient's most recent recorded dry weight in pounds **OR** kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15 Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. **Check only one box for each time period**. If patient is under 6 years of age, leave blank.

16 **To be completed by the attending physician.** Check all co-morbid conditions that apply.

***Ischemic heart disease** includes prior coronary artery bypass (CABG), angioplasty and diagnoses of coronary artery disease (CAD)/Coronary Heart Disease.

***Cerebrovascular Disease** includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

***Peripheral Vascular Disease** includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

***Drug dependence** means dependent on illicit drugs.

17 If EPO (erythropoietin) was administered to this patient prior to dialysis treatments or kidney transplant, check "Yes". If EPO was not administered to this patient prior to dialysis treatments or kidney transplant, check "No".

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 18a thru 18h should contain initial laboratory values within 45 days of the most recent ESRD episode.

18a Enter the hematocrit value (%) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant. If hematocrit value is not available, complete 18b. hemoglobin.

18b Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant. Enter value if hematocrit is not available.

18c Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant.

18d Enter the lower limit of the normal range for serum albumin (g/dl) from the laboratory which performed the serum albumin test entered in 18c.

18e Enter the serum creatinine value (mg/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant. **THIS FIELD MUST BE COMPLETED**.

NOTE: Except for diabetic and transplant patients, it has been determined by a consensus panel that the value of this field should be greater than or equal to 8.0 for a patient to receive renal replacement therapy without further justification. If this value is less than 8.0 AND creatinine clearance is equal to or greater than 10.0 this case will be subject to ESRD Network Medical Review Board Review. In these cases, please annotate in Remarks (Item 49) additional medical evidence to support renal replacement therapy. If there is not enough room in the remarks section, you may attach an additional sheet of paper.

18f If value of 18e. serum creatinine is < 8.0 mg/dl, enter creatinine clearance value (ml/min) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant. If these data are not available, creatinine clearance will be computed, therefore Items 13 and 14 must be completed.

18g If value of 18e. serum creatinine is < 8.0 mg/dl, enter BUN value (mg/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or transplant.

18h If value of 18e. serum creatinine is < 8.0 mg/dl and 18f. creatinine clearance is > 10.0, enter the urea clearance value (ml/min) and date test was taken. This value and date must be 45 days prior to the first dialysis treatment or transplant.

19 Enter the name of the dialysis provider where patient is currently receiving care and who is completing this form for patient.

20 Enter the 6-digit Medicare identification code of the dialysis facility in item 19.

21 If a person is receiving a regular course of dialysis treatment, check the appropriate **anticipated long term treatment setting** at the time this form is being completed. If a patient is a resident of and receives their dialysis in an intermediate care facility or nursing home, check home.

22 If the patient is, or was, on regular dialysis, **check the anticipated long term primary type of dialysis**: Hemodialysis, IPD (Intermittent Peritoneal Dialysis), CAPD (Continuous Ambulatory Peritoneal Dialysis), CCPD (Continuous Cycle Peritoneal Dialysis), or Other. **Check only one block**. NOTE: Other has been placed on this form to be used only if a new method of dialysis is developed prior to the renewal of this form by Office of Management and Budget.

23 Enter the date (month, day, year) that a "regular course of dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Dialysis Began" regardless of whether this prescription was implemented in a hospital inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 49, that patient is restarting dialysis.

24 Enter date patient started chronic dialysis at current provider of dialysis services. In cases where patient transferred to current dialysis provider, this date will be after the date in Item 23.

25 If a patient began a regular course of dialysis, then stopped dialysis therapy, enter the last dialysis treatment date. Examples of when this field should be completed are: (1) dialysis stopped due to transplant; (2) patient died during Medicare 3-month qualifying period (also complete item 26); (3) patient withdrew from treatment.

26 If the patient has died, enter the date of death. If date of death is completed, please also complete HCFA-2746 ESRD Death Notification and attach to ESRD Network copy of HCFA-2728.

27 Enter the date(s) of the patient's kidney transplant(s). If re-entering the Medicare program, enter current transplant date.

28 Enter the name of the hospital where the patient received a kidney transplant on the date in Item 27.

29 Enter the 6-digit Medicare identification code of the hospital in Item 28 where the patient received a kidney transplant on the date entered in Item 27.

30 Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.

31 Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.

32 Enter the 6-digit Medicare identification number for hospital in Item 31.

33 Check the appropriate functioning or nonfunctioning block.

34 If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post transplant, enter transplant date.

35 If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting.

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 36-43 if the patient has entered into a self-dialysis training program. Items 36-43 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

36 Enter the name of the provider furnishing self-care dialysis training.

37 Enter the 6-digit Medicare identification number for the training provider in Item 36.

38 Enter the date self-dialysis training began. (While it is expected that this date will be after the date patient started a regular course of dialysis, it should not be more than 30 days prior to the start of a regular course of dialysis.)

39 Check the appropriate block which describes the type of self-care dialysis training the patient began.

40 Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.

41 Enter date patient completed or is expected to complete self-dialysis training.

42 Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.

43 Unique Physician Identification Number (UPIN) of physician in Item 42. (See Item 46 for explanation of UPIN.)

44 Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.

45 Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.

46 Enter the physician's UPIN assigned by HCFA.

A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part B Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.

47 To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 44. A stamped signature is unacceptable.

48 Enter date physician signed this form.

49 This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.

50 The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.

51 The date patient signed form.

NOTICE

This form is to be completed for all End Stage Renal Disease patients beginning April 1, 1995, regardless of when the patient started dialysis or received a kidney transplant. Prior blank versions of this form should be destroyed. Old versions of the HCFA-2728 will not be accepted by the Social Security Administration or the ESRD Network Coordinating Councils after March 31, 1995.