Appendix D: Data Collection Forms, Part 1: CMS ESRD Forms

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CMS 2728-Chronic Renal Disease Medical Evidence Report (v. 1987)
CMS 2728-ESRD Medical Evidence Report Medicare Entitlement &/or Patient Registration (v. 1995)
CMS 2728-ESRD Medical Evidence Report Medicare Entitlement &/or Patient Registration (v. 2005)
CMS 2728 ESRD Medical Evidence Report Medicare Entitlement &/or Patient Registration (v. 2015)
CMS 2746-ESRD Death Notification (v. 1976)
CMS 2746-ESRD Death Notification (v. 1996)
CMS 2746-ESRD Death Notification (v. 2004)
CMS 2744-ESRD Facility Survey
UB92-CMS 1450-Uniform Bill
CMS 1500-Health Insurance Claim Form
### CHRONIC RENAL DISEASE MEDICAL EVIDENCE REPORT

#### IDENTIFYING INFORMATION

| 1. PATIENT'S NAME (LAST, FIRST, INITIAL) | 2. PATIENT'S OWN SOCIAL SECURITY NUMBER |
| 3. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP) | 4. PATIENT'S CLAIM NUMBER |
| 5. PHONE NO. | 6. DATE OF BIRTH |
| 7. RACE * | a. AMERICAN INDIAN OR ALASKAN NATIVE | b. ASIAN OR PACIFIC ISLANDER |
| | c. BLACK | d. WHITE |
| 8. ADDRESS OF SOCIAL SECURITY OFFICE | 9. PATIENT'S SEX * |
| | a. MALE | b. FEMALE |
| 10. PRIMARY DIAGNOSIS (CAUSE OF ESPR) ** |

#### TREATMENT INFORMATION—DIALYSIS

<table>
<thead>
<tr>
<th>TYPE OF DIALYSIS</th>
<th>DATE REGULAR DIALYSIS BEGAN</th>
<th>FREQUENCY SINCE REGULAR DIALYSIS BEGAN (TIMES PER WEEK)</th>
<th>HAS DIALYSIS ENDED? IF ENDED, DATE OF LAST DIALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12a. HEMODIALYS</td>
<td>12c.</td>
<td>12d. YES</td>
<td>12e. NO</td>
</tr>
<tr>
<td>13a. PERITONEAL</td>
<td>13c.</td>
<td>13d. YES</td>
<td>13e. NO</td>
</tr>
<tr>
<td>GAPD</td>
<td>GPD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TREATMENT INFORMATION—TRANSPLANT

<table>
<thead>
<tr>
<th>16. DATE(S) OF TRANSPLANT</th>
<th>17. NAME OF TRANSPLANT HOSPITAL</th>
<th>18. PROVIDER NO</th>
</tr>
</thead>
</table>

#### TREATMENT INFORMATION—TRANSPLANT

<table>
<thead>
<tr>
<th>19. WAS THE PATIENT ADMITTED AS AN INPATIENT TO A HOSPITAL IN PREPARATION FOR OR ANTICIPATION OF A RENAL TRANSPLANT PRIOR TO THE DATE OF ACTUAL TRANSPLANTATION?</th>
<th>20. IF YES, ENTER DATES</th>
<th>21. NAME OF HOSPITAL FOR ITEM 19</th>
<th>22. PROVIDER NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>23. CURRENT STATUS OF TRANSPLANT (IF a. CHECKED, ANSWER 24 OR EXPLAIN IN REMARKS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. FUNCTIONING</td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>24. DATE OF RETURN TO REGULAR DIALYSIS</th>
</tr>
</thead>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>26. DO YOU CERTIFY THAT THIS PATIENT HAS REACHED THE STATE OF RENAL IMPAIRMENT THAT APPEARS IRREVERSIBLE AND PERMANENT AND REQUIRED A REGULAR COURSE OF DIALYSIS OR RENAL TRANSPLANTATION TO MAINTAIN LIFE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>27. NAME ADDRESS OF TRAINING PROVIDER</th>
<th>28. DATE TRAINING BEGAN</th>
<th>29. TYPE OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NO.</td>
<td>28c.</td>
<td>a. HEMODIALYS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. GAPD</td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>30. HAS THE PATIENT COMPLETED THE TRAINING PROGRAM?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>32. I CERTIFY THAT THE ABOVE SELF-DIALYSIS TRAINING INFORMATION IS BASED ON CONSIDERATION OF ALL PERTINENT MEDICAL, PSYCHOLOGICAL, AND SOCIODEMOGRAPHIC FACTORS AS REFLECTED IN RECORDS KEPT BY THIS TRAINING FACILITY, AND IS CORRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE OF PHYSICIAN PERSONALY FAMILIAR WITH THE PATIENT'S TRAINING</td>
</tr>
<tr>
<td>TITLE</td>
</tr>
</tbody>
</table>

#### MEDICAL CERTIFICATION

<table>
<thead>
<tr>
<th>33. REMARKS</th>
</tr>
</thead>
</table>

#### MEDICAL CERTIFICATION

| 34. I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL AGENCY, OR OTHER ORGANIZATION TO DISCLOSE TO THE SOCIAL SECURITY ADMINISTRATION FOR PURPOSES OF REVIEWING MY APPLICATION FOR MEDICARE ENTITLEMENT UNDER THE SOCIAL SECURITY ACT, ANY MEDICAL RECORDS OR OTHER INFORMATION ABOUT MY MEDICAL CONDITION |

#### SIGNATURE OF PATIENT (SIGNATURE BY MARK MUST BE WITNESSED) | DATE |

Form HCFA-2728-U4 (6-87) **NOT REQUIRED TO OBTAIN BENEFIT, WILL BE USED FOR STATISTICS ONLY.**
# 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

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
   - [ ] Unknown

10. **Medical Coverage** (Check all that apply)
   - [ ] Medicaid
   - [ ] DVA
   - [ ] Medicare
   - [ ] Employer Group Health Insurance
   - [ ] Other Medical Insurance
   - [ ] None

11. Is Patient Applying for ESRD Medicare Coverage? (if YES, enter address of Social Security office)
   - [ ] Yes
   - [ ] No

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

13. **Height**

14. **Dry Weight**

15. **Employment Status** (6 mos. prior and current status)
   - [ ] 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 or during last 10 years) *See instructions
   - [ ] Congestive heart failure
   - [ ] Ischemic heart disease, CAD*
   - [ ] Myocardial infarction
   - [ ] Cardiac arrest
   - [ ] Cardiac dysrhythmia
   - [ ] Pericarditis
   - [ ] Cerebrovascular disease, CVA, TIA*
   - [ ] Peripheral vascular disease*
   - [ ] History of hypertension
   - [ ] Diabetes (primary or contributing)
   - [ ] Diabetes, currently on insulin
   - [ ] Chronic obstructive pulmonary disease
   - [ ] Tobacco use (current smoker)
   - [ ] Malignant neoplasm, Cancer
   - [ ] Alcohol dependence
   - [ ] Drug dependence*
   - [ ] HIV positive status
   - [ ] AIDS
   - [ ] Inability to ambulate
   - [ ] Inability to transfer
   - [ ] Can’t Disclose

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

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

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

### 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**

24. **Date Patient Started Chronic Dialysis at Current Facility**

25. **Date Dialysis Stopped**

26. **Date of Death**

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CMS-2728-U3 (6-97)
C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS
27. Date of Transplant
   / / YYYY
28. Name of Transplant Hospital
29. Medicare Provider Number for Item 28

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
   / / YYYY
31. Name of Preparation Hospital
32. Medicare Provider Number for Item 31

33. Current Status of Transplant
   ☐ Functioning ☐ Non-Functioning

34. If Nonfunctioning, Date of Return To Regular Dialysis
   / / YYYY
35. Current Dialysis Treatment Site
   ☐ 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
   / / YYYY
39. Type of Training
   ☐ Hemodialysis ☐ IPD ☐ CAPD ☐ CCPD

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

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
   / / YYYY
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
   / / YYYY

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
   ☐ Yes ☐ No
53. Authorized Signature
54. Date
   / / YYYY
55. Network Number
   / / YYYY
**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.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>25000</td>
<td>A</td>
<td>Type II, adult-onset type or unspecified type diabetes</td>
</tr>
<tr>
<td>25001</td>
<td>A</td>
<td>Type I, juvenile type, ketosis prone diabetes</td>
</tr>
</tbody>
</table>

**DIABETES**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>25000</td>
<td>A</td>
<td>Type II, adult-onset type or unspecified type diabetes</td>
</tr>
<tr>
<td>25001</td>
<td>A</td>
<td>Type I, juvenile type, ketosis prone diabetes</td>
</tr>
</tbody>
</table>

**HYPERTENSION/LARGE VESSEL DISEASE**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4039</td>
<td>D</td>
<td>Renal disease due to hypertension (no primary renal disease)</td>
</tr>
<tr>
<td>4401</td>
<td>A</td>
<td>Renal artery stenosis</td>
</tr>
<tr>
<td>59381</td>
<td>B</td>
<td>Renal artery occlusion</td>
</tr>
<tr>
<td>59381</td>
<td>E</td>
<td>Cholesterol emboli, renal emboli</td>
</tr>
</tbody>
</table>

**CYSTIC/HEREDITARY/CONGENITAL DISEASES**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>75313</td>
<td>A</td>
<td>Polycystic kidneys, adult type (dominant)</td>
</tr>
<tr>
<td>75314</td>
<td>A</td>
<td>Polycystic, infantile (recessive)</td>
</tr>
<tr>
<td>75316</td>
<td>A</td>
<td>Medullary cystic disease, including nephronophthisis</td>
</tr>
<tr>
<td>7595</td>
<td>A</td>
<td>Tuberos, sclerosis</td>
</tr>
<tr>
<td>7598</td>
<td>A</td>
<td>Hereditary nephritis, Alport’s syndrome</td>
</tr>
<tr>
<td>2700</td>
<td>A</td>
<td>Cystinosis</td>
</tr>
<tr>
<td>2718</td>
<td>B</td>
<td>Primary oxalosis</td>
</tr>
<tr>
<td>2727</td>
<td>A</td>
<td>Fabry’s disease</td>
</tr>
<tr>
<td>7533</td>
<td>A</td>
<td>Congenital nephrotic syndrome</td>
</tr>
<tr>
<td>5839</td>
<td>D</td>
<td>Drash syndrome, mesangial sclerosis</td>
</tr>
<tr>
<td>7532</td>
<td>A</td>
<td>Congenital obstructive uropathy</td>
</tr>
<tr>
<td>7530</td>
<td>B</td>
<td>Renal hypoplasia, dysplasia, oligonephronia</td>
</tr>
</tbody>
</table>

**SECONDARY GN/vasculitis**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7100</td>
<td>E</td>
<td>Lupus erythematosus, (SLE nephritis)</td>
</tr>
<tr>
<td>2870</td>
<td>A</td>
<td>Henoch-Schonlein syndrome</td>
</tr>
<tr>
<td>7101</td>
<td>B</td>
<td>Scleroderma</td>
</tr>
<tr>
<td>2831</td>
<td>A</td>
<td>Hemolytic uremic syndrome</td>
</tr>
<tr>
<td>4460</td>
<td>C</td>
<td>Polyarteritis</td>
</tr>
<tr>
<td>4464</td>
<td>B</td>
<td>Wegener’s granulomatosis</td>
</tr>
<tr>
<td>5839</td>
<td>C</td>
<td>Nephropathy due to heroin abuse and related drugs</td>
</tr>
<tr>
<td>4462</td>
<td>A</td>
<td>Vasculitis and its derivatives</td>
</tr>
<tr>
<td>5839</td>
<td>B</td>
<td>Secondary GN, other</td>
</tr>
</tbody>
</table>

**NEOPLASMS/TUMORS**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>B</td>
<td>Renal tumor (malignant)</td>
</tr>
<tr>
<td>1899</td>
<td>A</td>
<td>Urinary tract tumor (malignant)</td>
</tr>
<tr>
<td>2230</td>
<td>A</td>
<td>Renal tumor (benign)</td>
</tr>
<tr>
<td>2239</td>
<td>A</td>
<td>Urinary tract tumor (benign)</td>
</tr>
<tr>
<td>2395</td>
<td>A</td>
<td>Renal tumor (unspecified)</td>
</tr>
<tr>
<td>2395</td>
<td>B</td>
<td>Urinary tract tumor (unspecified)</td>
</tr>
<tr>
<td>20280</td>
<td>A</td>
<td>Lymphoma of kidneys</td>
</tr>
<tr>
<td>2030</td>
<td>A</td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td>2030</td>
<td>B</td>
<td>Light chain nephropathy</td>
</tr>
<tr>
<td>2773</td>
<td>A</td>
<td>Amyloidosis</td>
</tr>
<tr>
<td>99680</td>
<td>A</td>
<td>Complication post bone marrow or other transplant</td>
</tr>
</tbody>
</table>

**INTERSTITIAL NEPHRITIS/PYELONEPHRITIS**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9659</td>
<td>A</td>
<td>Analgesic abuse</td>
</tr>
<tr>
<td>5830</td>
<td>B</td>
<td>Radiation nephritis</td>
</tr>
<tr>
<td>9849</td>
<td>A</td>
<td>Lead nephropathy</td>
</tr>
<tr>
<td>5909</td>
<td>A</td>
<td>Nephropathy caused by other agents</td>
</tr>
<tr>
<td>27410</td>
<td>A</td>
<td>Gouty nephropathy</td>
</tr>
<tr>
<td>5920</td>
<td>C</td>
<td>Nephrolithiasis</td>
</tr>
<tr>
<td>5996</td>
<td>A</td>
<td>Acquired obstructive uropathy</td>
</tr>
<tr>
<td>5900</td>
<td>A</td>
<td>Chronic pyelonephritis, reflux nephropathy</td>
</tr>
<tr>
<td>58389</td>
<td>B</td>
<td>Chronic interstitial nephritis</td>
</tr>
<tr>
<td>58089</td>
<td>A</td>
<td>Acute interstitial nephritis</td>
</tr>
<tr>
<td>5929</td>
<td>U</td>
<td>Urolithiasis</td>
</tr>
<tr>
<td>2754</td>
<td>A</td>
<td>Nephrocalcinosis</td>
</tr>
</tbody>
</table>

**MISCELLANEOUS CONDITIONS**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>LTR</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>28260</td>
<td>A</td>
<td>Sickle cell disease/anemia</td>
</tr>
<tr>
<td>28269</td>
<td>A</td>
<td>Sickle cell trait and other sickle cell (HbS/Hb other)</td>
</tr>
<tr>
<td>64620</td>
<td>A</td>
<td>Post partum renal failure</td>
</tr>
<tr>
<td>0429</td>
<td>A</td>
<td>AIDS nephropathy</td>
</tr>
<tr>
<td>8660</td>
<td>A</td>
<td>Traumatic or surgical loss of kidney(s)</td>
</tr>
<tr>
<td>5724</td>
<td>A</td>
<td>Hepatorenal syndrome</td>
</tr>
<tr>
<td>5836</td>
<td>A</td>
<td>Tubular necrosis (no recovery)</td>
</tr>
<tr>
<td>59389</td>
<td>A</td>
<td>Other renal disorders</td>
</tr>
<tr>
<td>7999</td>
<td>A</td>
<td>Etiology uncertain</td>
</tr>
</tbody>
</table>
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. For all patients who initially receive a kidney transplant instead of a course of dialysis.
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.
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.

According to the Paperwork Reduction Act of 1995, no persons are required to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection is estimated to average 25 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.
**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.

18.a. 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 18.b. hemoglobin.

18.b. 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.

18.d. 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.

18.e. 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.

18.f. If value of 18.e., 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 the first dialysis treatment or transplant. If these data are not available, creatinine clearance will be computed, therefore Items 13 and 14 must be completed.

18.g. If value of 18.e., serum creatinine, is < 8.0 mg/dl and 18.f., 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.

18.h. If value of 18.e., serum creatinine, is < 8.0 mg/dl and 18.f., 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 CMS-2746 ESRD Death Notification and attach to ESRD Network copy of CMS-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.
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 CMS.
   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. Versions of the HCFA-2728 dated prior to April 1995 will not be accepted by the Social Security Administration or the ESRD Network Coordinating Councils.
END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT

MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS  

Check one: ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name  (Last, First, Middle Initial)

2. Medicare Claim Number  

3. Social Security Number  

4. Date of Birth MM DD YYYY

5. Patient Mailing Address (Include City, State and Zip)

6. Phone Number 

7. Sex  

☐ Male  ☐ Female

8. Ethnicity

☐ Not Hispanic or Latino  ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race (Check all that apply)

☐ White  ☐ Black or African American  ☐ American Indian/Alaska Native

☐ Asian  ☐ Native Hawaiian or Other Pacific Islander*  ☐ Other

Print Name of Enrolled/Principal Tribe ____________________ *complete Item 9

11. Is patient applying for ESRD Medicare coverage?  

☐ Yes  ☐ No

12. Current Medical Coverage (Check all that apply)

☐ Medicaid  ☐ Medicare  ☐ Employer Group Health Insurance  ☐ VA

☐ Medicare Advantage  ☐ Other  ☐ None

13. Height  

INCHES _______ OR CENTIMETERS _______ 

14. Dry Weight  

POUNDS _______ OR KILOGRAMS _______ 

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

☐ None

16. 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

17. Co-Morbid Conditions (Check all that apply currently and/or during last 10 years) *See instructions

☐ p. Atherosclerotic heart disease ASHD  ☐ q. Other cardiac disease

☐ r. Cerebrovascular disease, CVA, TIA*  ☐ s. Peripheral vascular disease*

☐ t. History of hypertension  ☐ u. Amputation

☐ v. Diabetes, on oral medications  ☐ w. Diabetes, currently on insulin

☐ x. Diabetes, on insulin nasal spray  ☐ y. Diabetes, on insulin injection

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent?  

☐ Yes  ☐ No  ☐ Unknown  

If Yes, answer: ☐ 6-12 months ☐ >12 months

b. Was patient under care of a nephrologist?  

☐ Yes  ☐ No  ☐ Unknown

If Yes, answer: ☐ 6-12 months ☐ >12 months

c. Was patient under care of kidney dietitian?  

☐ Yes  ☐ No  ☐ Unknown

If Yes, answer: ☐ 6-12 months ☐ >12 months

d. What access was used on first outpatient dialysis:

If not AVF, then: Is maturing AVF present?  

☐ Yes  ☐ No

If Yes, answer:  

If Yes, answer:

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

<table>
<thead>
<tr>
<th>LABORATORY TEST</th>
<th>VALUE</th>
<th>DATE</th>
<th>LABORATORY TEST</th>
<th>VALUE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Serum Albumin (g/dl)</td>
<td>____.</td>
<td>____.</td>
<td>d. HbA1c</td>
<td>____.</td>
<td>%</td>
</tr>
<tr>
<td>a. Serum Albumin Lower Limit</td>
<td>___.</td>
<td>_____</td>
<td>e. Lipid Profile</td>
<td>TC</td>
<td>_____</td>
</tr>
<tr>
<td>a.3. Lab Method Used (BCG or BCP)</td>
<td></td>
<td></td>
<td>LDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Serum Creatinine (mg/dl)</td>
<td>____.</td>
<td>____</td>
<td>HDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Hemoglobin (g/dl)</td>
<td>____.</td>
<td>____</td>
<td>TG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

21. Medicare Provider Number (for item 20)

22. Primary Dialysis Setting

☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis

☐ Hemodialysis (Sessions per week____/hours per session____)  

☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began MM DD YYYY

25. Date Patient Started Chronic Dialysis at Current Facility MM DD YYYY

26. Has patient been informed of kidney transplant options?

☐ Yes  ☐ No

27. If patient NOT informed of transplant options, please check all that apply:

☐ Medically unfit  ☐ Patient declines information

☐ Unsuitable due to age  ☐ Patient has not been assessed

☐ Psychologically unfit  ☐ Other
C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant
   MM DD YYYY

29. Name of Transplant Hospital

30. Medicare Provider Number for Item 29

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.

31. Enter Date
   MM DD YYYY

32. Name of Preparation Hospital

33. Medicare Provider number for Item 32

34. Current Status of Transplant (If functioning, skip items 36 and 37)
   ☐ Functioning
   ☐ Non-Functioning

35. Type of Donor:
   ☐ Deceased
   ☐ Living Related
   ☐ Living Unrelated

36. If Non-Functioning, Date of Return to Regular Dialysis
   MM DD YYYY

37. Current Dialysis Treatment Site
   ☐ Home
   ☐ Dialysis Facility/Center
   ☐ SNF/Long Term Care Facility

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

38. Name of Training Provider

39. Medicare Provider Number of Training Provider (for Item 38)

40. Date Training Began
   MM DD YYYY

41. Type of Training
   ☐ Hemodialysis
   ☐ CAPD
   ☐ CCPD
   ☐ Other

42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis.
   ☐ Yes
   ☐ No

43. Date When Patient Completed, or is Expected to Complete, Training
   MM DD YYYY

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.

44. Printed Name and Signature of Physician personally familiar with the patient’s training

45. UPIN of Physician in Item 44
   a.) Printed Name
   b.) Signature
   c.) Date

E. PHYSICIAN IDENTIFICATION

46. Attending Physician (Print)

47. Physician’s Phone No.

48. UPIN of Physician in Item 46

49. Attending Physician’s Signature of Attestation (Same as Item 46)

50. Date
   MM DD YYYY

51. Physician Recertification Signature

52. Date
   MM DD YYYY

53. 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.

54. Signature of Patient (Signature by mark must be witnessed.)

55. Date
   MM DD YYYY

G. PRIVACY 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 Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 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 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.
**LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE**

Item 15. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. *Code effective as of September 2003.*

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>NARRATIVE</th>
<th>ICD-9</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25040</td>
<td>Diabetes with renal manifestations Type 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25041</td>
<td>Diabetes with renal manifestations Type 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GLOMERULONEPHRITIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5829</td>
<td>Glomerulonephritis (GN)</td>
<td>75313</td>
<td>Polycystic kidneys, adult type (dominant)</td>
</tr>
<tr>
<td>5821</td>
<td>(histologically not examined)</td>
<td>75314</td>
<td>Polycystic, infantile (recessive)</td>
</tr>
<tr>
<td>5831</td>
<td>Membranous nephropathy</td>
<td>75316</td>
<td>Medullary cystic disease, including nephronophthis</td>
</tr>
<tr>
<td>58321</td>
<td>Membranoproliferative GN type 1, diffuse MPGN</td>
<td>7595</td>
<td>Tuberous sclerosis</td>
</tr>
<tr>
<td>58322</td>
<td>Dense deposit disease, MPGN type 2</td>
<td>7598</td>
<td>Hereditary nephritis, Alport’s syndrome</td>
</tr>
<tr>
<td>58381</td>
<td>IgA nephropathy, Berger’s disease (proven by immunofluorescence)</td>
<td>2700</td>
<td>Cystinosis</td>
</tr>
<tr>
<td>58382</td>
<td>IgM nephropathy (proven by immunofluorescence)</td>
<td>2718</td>
<td>Primary oxalosis</td>
</tr>
<tr>
<td>5834</td>
<td>With lesion of rapidly progressive GN</td>
<td>2727</td>
<td>Fabry’s disease</td>
</tr>
<tr>
<td>5800</td>
<td>Post infectious GN, SBE</td>
<td>7533</td>
<td>Congenital nephrotic syndrome</td>
</tr>
<tr>
<td>5820</td>
<td>Other proliferative GN</td>
<td>5839</td>
<td>Drash syndrome, mesangial sclerosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75321</td>
<td>Congenital obstruction of ureterpelvic junction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75322</td>
<td>Congenital obstruction of uretervesical junction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75329</td>
<td>Other Congenital obstructive ureopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7530</td>
<td>Renal hypoplasia, dysplasia, oligonephronia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75671</td>
<td>Prune belly syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75989</td>
<td>Other (congenital malformation syndromes)</td>
</tr>
<tr>
<td><strong>SECONDARY GN/VASCULITIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7100</td>
<td>Lupus erythematosus, (SLE nephritis)</td>
<td>1890</td>
<td>Renal tumor (malignant)</td>
</tr>
<tr>
<td>2870</td>
<td>Henoch-Schonlein syndrome</td>
<td>1899</td>
<td>Urinary tract tumor (malignant)</td>
</tr>
<tr>
<td>7101</td>
<td>Scleroderma</td>
<td>2230</td>
<td>Renal tumor (benign)</td>
</tr>
<tr>
<td>28311</td>
<td>Hemolytic uremic syndrome</td>
<td>2239</td>
<td>Urinary tract tumor (benign)</td>
</tr>
<tr>
<td>4460</td>
<td>Polyarteritis</td>
<td>23951</td>
<td>Renal tumor (unspecified)</td>
</tr>
<tr>
<td>4464</td>
<td>Wegener’s granulomatosis</td>
<td>23952</td>
<td>Urinary tract tumor (unspecified)</td>
</tr>
<tr>
<td>58392</td>
<td>Nephropathy due to heroin abuse and related drugs</td>
<td>20280</td>
<td>Lymphoma of kidneys</td>
</tr>
<tr>
<td>44620</td>
<td>Other Vasculitis and its derivatives</td>
<td>20300</td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td>44621</td>
<td>Goodpasture’s syndrome</td>
<td>20308</td>
<td>Other immuno proliferative neoplasms (including light chain nephropathy)</td>
</tr>
<tr>
<td>58391</td>
<td>Secondary GN, other</td>
<td>2773</td>
<td>Amyloidosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99680</td>
<td>Complications of transplanted organ unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99681</td>
<td>Complications of transplanted kidney</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99682</td>
<td>Complications of transplanted liver</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99683</td>
<td>Complications of transplanted heart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99684</td>
<td>Complications of transplanted lung</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99685</td>
<td>Complications of transplanted bone marrow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99686</td>
<td>Complications of transplanted pancreas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99687</td>
<td>Complications of transplanted intestine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99689</td>
<td>Complications of other specified transplanted organ</td>
</tr>
<tr>
<td><strong>INTERSTITIAL NEPHRITIS/PYELONEPHRITIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9659</td>
<td>Analgesic abuse</td>
<td>28260</td>
<td>Sickle cell disease/anemia</td>
</tr>
<tr>
<td>5830</td>
<td>Radiation nephritis</td>
<td>28269</td>
<td>Sickle cell trait and other sickle cell (HbS/Hb other)</td>
</tr>
<tr>
<td>9849</td>
<td>Lead nephropathy</td>
<td>64620</td>
<td>Post partum renal failure</td>
</tr>
<tr>
<td>5909</td>
<td>Nephropathy caused by other agents</td>
<td>042</td>
<td>AIDS nephropathy</td>
</tr>
<tr>
<td>27410</td>
<td>Gouty nephropathy</td>
<td>8660</td>
<td>Traumatic or surgical loss of kidney(s)</td>
</tr>
<tr>
<td>5920</td>
<td>Nephrolithias</td>
<td>5724</td>
<td>Hepatorenal syndrome</td>
</tr>
<tr>
<td>5996</td>
<td>Acquired obstructive uropathy</td>
<td>5836</td>
<td>Tubular necrosis (no recovery)</td>
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<tr>
<td>5900</td>
<td>Chronic pyelonephritis, reflux nephropathy</td>
<td>59389</td>
<td>Other renal disorders</td>
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<tr>
<td>58389</td>
<td>Chronic interstitial nephritis</td>
<td>7999</td>
<td>Etiology uncertain</td>
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<tr>
<td>58089</td>
<td>Acute interstitial nephritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5929</td>
<td>Urolithias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27549</td>
<td>Other disorders of calcium metabolism</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HYPERTENSION/LARGE VESSEL DISEASE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40391</td>
<td>Unspecified with renal failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4401</td>
<td>Renal artery stenosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59381</td>
<td>Renal artery occlusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59383</td>
<td>Cholesterol emboli, renal emboli</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FORM CMS-2728-U3 (06/04)
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:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis.

For 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. The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

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.

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 ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

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 15, 17-18, 26-27, 49-50: To be completed by the attending physician.

Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.

Items 54 and 55: 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 Medicare claim number as it appears on 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 patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.

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

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

7. Check the appropriate block to identify sex.

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

Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.

10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

• Forward the first part (blue) of this form to the Social Security office servicing the claim.

• Forward the second part (green) of this form to the ESRD Network Organizations.

• Retain the last part (white) in the patient's medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
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/she should reapply for ESRD Medicare coverage.

12. Check all the boxes that apply to this patient's current medical insurance status.

   - **Medicaid**—Patient is currently receiving State Medicaid benefits.
   - **Medicare**—Patient is currently entitled to Federal Medicare benefits.
   - **Employer Group Health Insurance**—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees or former employees.
   - **DVA**—Patient is receiving medical care from a Department of Veterans Affairs facility.
   - **Medicare Advantage**—Patient is receiving medical benefits under a Medicare Advantage organization.
   - **Other Medical Insurance**—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, 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.

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. To be completed by the attending physician. Enter the ICD-9-CM 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.

16. 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.

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

   - **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.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received Exogenous erythropoetin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

**Note:** For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. 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 kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. **This Field Must Be Completed.** Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC—Total Cholesterol; LDL—LDL Cholesterol; HDL—HDL Cholesterol; TG—Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

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

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

22. If the 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.

23. If the patient is, or was, on regular dialysis, check the **anticipated long-term primary type of dialysis:** Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. **Check only one block.** **Note:** Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a “regular course of chronic 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 Chronic 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 53, that patient is restarting dialysis.**

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

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.
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 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 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.

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

Enter the 6-digit Medicare identification number for the training provider in Item 38.

Enter the date self-dialysis training began.

Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.

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.

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

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

Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)

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

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.

Enter the physician’s UPIN assigned by CMS.

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.

To be signed by the physician supervising the patient’s kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.

Enter date physician signed this form.

To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.

The date physician re-certified and signed the form.

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

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.

The date patient signed form.

NOTICE

This form is to be completed for all End Stage Renal Disease patients beginning June 01, 2005 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 CMS-2728 will not be accepted by the Social Security Administration or the ESRD Network Organizations after May 31, 2005.
END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS  
Check one: ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name (Last, First, Middle Initial)

2. Medicare Claim Number

3. Social Security Number

4. Date of Birth (mm/dd/yyyy)

5. Patient Mailing Address (Include City, State and Zip)

6. Phone Number (including area code)

7. Sex  
☐ Male ☐ Female

8. Ethnicity  
☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race (Check all that apply)  
☐ White ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander*  
☐ American Indian/Alaska Native ☐ Complete Item 9

Print Name of Enrolled/Principal Tribe

11. Is patient applying for ESRD Medicare coverage?  
☐ Yes ☐ No

12. Current Medical Coverage (Check all that apply)  
☐ Medicare ☐ Medicaid ☐ Kaiser Permanente  
☐ DVA ☐ Medicare Advantage ☐ HHCAHPS

13. Height INCHES OR CENTIMETERS

14. Dry Weight POUNDS OR KILOGRAMS

15. Primary Cause of Renal Failure (Use ICD-10-CM Code)

16. Employment Status (6 mos. prior and current status)  
☐ Unemployed ☐ Employed Full Time
☐ Employed Part Time ☐ Homemaker
☐ Retired due to Age/Preference ☐ Retired (Disability)
☐ Medical Leave of Absence ☐ Student

17. Co-Morbid Conditions (Check all that apply currently and/or during last 10 years)  
See instructions for item 16:

a. Congestive heart failure
b. Atherosclerotic heart disease ASHD
c. Other cardiac disease
d. Cerebrovascular disease, CVA, TIA*
e. Peripheral vascular disease*
f. History of hypertension
g. Amputation
h. Diabetes, currently on insulin
i. Diabetes, on oral medications
j. Diabetes, without medications
k. Diabetic retinopathy
l. Chronic obstructive pulmonary disease
m. Tobacco use (current smoker)

n. Malignant neoplasm, Cancer
o. Toxic nephropathy
p. Alcohol dependence
q. Drug dependence*
r. Inability to ambulate
s. Inability to transfer
t. Needs assistance with daily activities
u. Institutionalized
v. Non-renal congenital abnormality
w. None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoietin or equivalent?  
☐ Yes ☐ No ☐ Unknown  
If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

b. Was patient under care of a nephrologist?  
☐ Yes ☐ No ☐ Unknown  
If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

c. Was patient under care of kidney dietician?  
☐ Yes ☐ No ☐ Unknown  
If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

d. What access was used on first outpatient dialysis:  
☐ AVF ☐ Graft ☐ Catheter ☐ Other

If not AVF, then:  
Is maturing AVF present?  
☐ Yes ☐ No

Is maturing graft present?  
☐ Yes ☐ No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

<table>
<thead>
<tr>
<th>LABORATORY TEST</th>
<th>VALUE</th>
<th>DATE</th>
<th>LABORATORY TEST</th>
<th>VALUE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.1. Serum Albumin (g/dl)</td>
<td></td>
<td></td>
<td>d. HbA1c</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>a.2. Serum Albumin Lower Limit</td>
<td></td>
<td></td>
<td>e. Lipid Profile</td>
<td>TC</td>
<td></td>
</tr>
<tr>
<td>a.3. Lab Method Used (BCG or BCP)</td>
<td>May 2013</td>
<td></td>
<td>LDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Serum Creatinine (mg/dl)</td>
<td></td>
<td></td>
<td>HDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Hemoglobin (g/dl)</td>
<td></td>
<td></td>
<td>TG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility

21. Medicare Provider Number (for item 20)

22. Primary Dialysis Setting

☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis

☐ Hemodialysis (Sessions per week ___/hours per session___)  
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began (mm/dd/yyyy)

25. Date Patient Started Chronic Dialysis at Current Facility (mm/dd/yyyy)

26. Has patient been informed of kidney transplant options?  
☐ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:  
☐ Medically unfit ☐ Patient declines information
☐ Unsuitable due to age ☐ Patient has not been assessed
☐ Psychologically unfit ☐ Other

1 Form Approved OMB No. 0938-0046
C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

<table>
<thead>
<tr>
<th>28. Date of Transplant (mm/dd/yyyy)</th>
<th>29. Name of Transplant Hospital</th>
<th>30. Medicare Provider Number for Item 29</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>31. Enter Date (mm/dd/yyyy)</th>
<th>32. Name of Preparation Hospital</th>
<th>33. Medicare Provider number for Item 32</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>34. Current Status of Transplant (if functioning, skip items 36 and 37)</th>
<th>35. Type of Donor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Functioning</td>
<td>□ Deceased</td>
</tr>
<tr>
<td>□ Non-Functioning</td>
<td>□ Living Related</td>
</tr>
<tr>
<td>□ Non-Functioning</td>
<td>□ Living Unrelated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>36. If Non-Functioning, Date of Return to Regular Dialysis (mm/dd/yyyy)</th>
<th>37. Current Dialysis Treatment Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Home</td>
</tr>
<tr>
<td></td>
<td>□ Dialysis Facility/Center</td>
</tr>
<tr>
<td></td>
<td>□ SNF/Long Term Care Facility</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>38. Name of Training Provider</th>
<th>39. Medicare Provider Number of Training Provider (for Item 38)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>40. Date Training Began (mm/dd/yyyy)</th>
<th>41. Type of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Hemodialysis</td>
</tr>
<tr>
<td></td>
<td>a. □ Home</td>
</tr>
<tr>
<td></td>
<td>b. □ In Center</td>
</tr>
<tr>
<td></td>
<td>□ CAPD</td>
</tr>
<tr>
<td></td>
<td>□ CCPD</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis.</th>
<th>43. Date When Patient Completed, or is Expected to Complete, Training (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>44. Printed Name and Signature of Physician personally familiar with the patient's training</th>
<th>45. UPIN of Physician in Item 44</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.) Printed Name</td>
<td>b.) Signature</td>
</tr>
<tr>
<td>c.) Date (mm/dd/yyyy)</td>
<td>c.) Date (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

E. PHYSICIAN IDENTIFICATION

<table>
<thead>
<tr>
<th>46. Attending Physician (Print)</th>
<th>47. Physician's Phone No. (Include Area Code)</th>
<th>48. UPIN of Physician in Item 46</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>49. Attending Physician's Signature of Attestation (Same as Item 46)</th>
<th>50. Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>51. Physician Recertification Signature</th>
<th>52. Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

| 53. 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.

<table>
<thead>
<tr>
<th>54. Signature of Patient (Signature by mark must be witnessed.)</th>
<th>55. Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

G. PRIVACY 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. 0970-0520, “End Stage Renal Disease Program Management and Medical Information System (ESRD PPMIS)”, published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 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 PPMIS 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 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.
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:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis. For 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.

The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

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.

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 ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

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 15, 17-18, 26-27, 49-50: To be completed by the attending physician.

Item 44: To be signed by the attending physician or the physician familiar with the patient’s self-care dialysis training.

Items 54 and 55: 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 Medicare claim number as it appears on 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 patient’s date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.

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

6. Enter the patient’s home area code and telephone number.

7. Check the appropriate block to identify sex.

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

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.

10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

   White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

   Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

   American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains Tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

   Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

   Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

• Forward one copy of this form to the Social Security office servicing the claim.

• Forward one copy of this form to the ESRD Network Organization.

• Retain one copy of this form in the patient’s medical records file.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this form is 0938-0046. The time required to complete this information collection estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Form CMS-2728-U3 (08/15)
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/she should reapply for ESRD Medicare coverage.

12. Check all the blocks that apply to this patient’s current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

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

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

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, 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.

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. To be completed by the attending physician. Enter the ICD10-CM Code to indicate the primary cause of end stage renal disease.

16. 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.

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

*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.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received exogenous erythropoietin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietician. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. 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 kidney transplant.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. Enter the serum creatinine value (mg/dl) and date test was taken. THIS FIELD MUST BE COMPLETED. Value must be within 45 days prior to first dialysis treatment or kidney transplant.

19c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

19d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19e. Enter the Lipid Profile values and date test was taken. These values: TC—Total Cholesterol; LDL—LDL Cholesterol; HDL—HDL Cholesterol; TG—Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

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

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

22. If the 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.

23. If the patient is, or was, on regular dialysis, check the anticipated long-term primary type of dialysis: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. Check only one block. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

24. Enter the date (month, day, year) that a “regular course of chronic 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 Chronic 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 53, that patient is restarting dialysis.

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

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered “no” to Item 26), then enter all reasons why a
kidney transplant was not an option for this patient at this time.

28. Enter the date(s) of the patient’s kidney transplant(s). If reentering the Medicare program, enter current transplant date.

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

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

31. 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.

32. 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.

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

34. Check the appropriate functioning or non-functioning block.

35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.

36. 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.

37. 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 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 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.

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

39. Enter the 6-digit Medicare identification number for the training provider in Item 38.

40. Enter the date self-dialysis training began.

41. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.

42. 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.

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

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

45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)

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

47. 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.

48. Enter the physician’s UPIN assigned by CMS.

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 Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.

49. To be signed by the physician supervising the patient’s kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.

50. Enter date physician signed this form.

51. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.

52. The date physician re-certified and signed the form.

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

54. 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.

55. The date patient signed form.
LIST OF PRIMARY CAUSES OF RENAL FAILURE

For item 15 on the CMS-2728 (8/15): Primary Cause of Renal Failure should be determined by the attending physician using the appropriate ICD-10-CM code. Enter the ICD-10-CM code for the primary cause of failure on Field #15 of the CMS-2728 Form. If there are several probable causes of renal failure, choose one as primary. An ICD-10-CM Code is effective as of October 1, 2015.

Note: This code list below does not include all renal-specific ICD-10 CM codes; please use the ICD-10 CM Manual to validate an appropriate code. CMS has posted a complete list of the 2016 ICD-10-CM valid codes and code titles on the CMS website at [https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html](https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html)

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.22</td>
<td>Type 1 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E10.29</td>
<td>Type 1 diabetes mellitus with other diabetic kidney complication</td>
</tr>
<tr>
<td>E11.22</td>
<td>Type 2 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E11.29</td>
<td>Type 2 diabetes mellitus with other diabetic kidney complication</td>
</tr>
<tr>
<td>N00.8</td>
<td>Acute nephritic syndrome with other morphologic changes</td>
</tr>
<tr>
<td>N01.9</td>
<td>Rapidly progressive nephritic syndrome with unspecified morphologic changes</td>
</tr>
<tr>
<td>N02.8</td>
<td>Recurrent and persistent hematuria with other morphologic changes</td>
</tr>
<tr>
<td>N03.0</td>
<td>Chronic nephritic syndrome with minor glomerular abnormality</td>
</tr>
<tr>
<td>N03.1</td>
<td>Chronic nephritic syndrome with focal and segmental glomerular lesions</td>
</tr>
<tr>
<td>N03.2</td>
<td>Chronic nephritic syndrome with diffuse membranous glomerulonephritis</td>
</tr>
<tr>
<td>N03.3</td>
<td>Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis</td>
</tr>
<tr>
<td>N03.4</td>
<td>Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis</td>
</tr>
<tr>
<td>N03.5</td>
<td>Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis</td>
</tr>
<tr>
<td>N03.6</td>
<td>Chronic nephritic syndrome with dense deposit disease</td>
</tr>
<tr>
<td>N03.7</td>
<td>Chronic nephritic syndrome with diffuse crescentic glomerulonephritis</td>
</tr>
<tr>
<td>N03.8</td>
<td>Chronic nephritic syndrome with other morphologic changes</td>
</tr>
<tr>
<td>N03.9</td>
<td>Chronic nephritic syndrome with unspecified morphologic changes</td>
</tr>
<tr>
<td>N04.0</td>
<td>Nephrotic syndrome with minor glomerular abnormality</td>
</tr>
<tr>
<td>N04.1</td>
<td>Nephrotic syndrome with focal and segmental glomerular lesions</td>
</tr>
<tr>
<td>N04.2</td>
<td>Nephrotic syndrome with diffuse membranous glomerulonephritis</td>
</tr>
<tr>
<td>N04.3</td>
<td>Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis</td>
</tr>
<tr>
<td>N04.4</td>
<td>Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis</td>
</tr>
<tr>
<td>N04.5</td>
<td>Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis</td>
</tr>
<tr>
<td>N04.6</td>
<td>Nephrotic syndrome with dense deposit disease</td>
</tr>
<tr>
<td>N04.7</td>
<td>Nephrotic syndrome with diffuse crescentic glomerulonephritis</td>
</tr>
<tr>
<td>N04.8</td>
<td>Nephrotic syndrome with other morphologic changes</td>
</tr>
<tr>
<td>N04.9</td>
<td>Nephrotic syndrome with unspecified morphologic changes</td>
</tr>
<tr>
<td>N05.9</td>
<td>Unspecified nephritic syndrome with unspecified morphologic changes</td>
</tr>
<tr>
<td>N07.0</td>
<td>Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality</td>
</tr>
<tr>
<td>D59.3</td>
<td>Hemolytic-uremic syndrome</td>
</tr>
<tr>
<td>D69.0</td>
<td>Allergic purpura</td>
</tr>
<tr>
<td>I77.89</td>
<td>Other specified disorders of arteries and arterioles</td>
</tr>
<tr>
<td>M31.0</td>
<td>Hypersensitivity angitis</td>
</tr>
<tr>
<td>M31.1</td>
<td>Thrombotic microangiopathy</td>
</tr>
<tr>
<td>M31.31</td>
<td>Wegener's granulomatosis with renal involvement</td>
</tr>
<tr>
<td>M31.7</td>
<td>Microscopic polyangiitis</td>
</tr>
<tr>
<td>M32.0</td>
<td>Drug-induced systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.1</td>
<td>Systemic lupus erythematosus, organ or system involvement unspecified</td>
</tr>
<tr>
<td>M32.14</td>
<td>Glomerular disease in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.15</td>
<td>Tubulo-interstitial nephropathy in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M34.89</td>
<td>Other systemic sclerosis</td>
</tr>
<tr>
<td>N10</td>
<td>Acute tubulo-interstitial nephritis</td>
</tr>
<tr>
<td>N11.9</td>
<td>Chronic tubulo-interstitial nephritis, unspecified</td>
</tr>
<tr>
<td>N13.70</td>
<td>Vesicoureteral-reflux, unspecified</td>
</tr>
<tr>
<td>N13.8</td>
<td>Other obstructive and reflux uropathy</td>
</tr>
</tbody>
</table>

LIST OF PRIMARY CAUSES OF RENAL FAILURE
Publish Date: 09/25/2015
<table>
<thead>
<tr>
<th>LIST OF PRIMARY CAUSES OF RENAL FAILURE</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

## Transplant Complications
- **T86.00** Unspecified complication of bone marrow transplant
- **T86.10** Unspecified complication of kidney transplant
- **T86.20** Unspecified complication of heart transplant
- **T86.40** Unspecified complication of liver transplant
- **T86.819** Unspecified complication of lung transplant
- **T86.859** Unspecified complication of intestine transplant
- **T86.899** Unspecified complication of other transplanted tissue

## Hypertension/Large Vessel Disease
- **I12.9** Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
- **I15.0** Renovascular hypertension
- **I15.8** Other secondary hypertension
- **I75.81** Atheroembolism of kidney

## Cystic/Hereditary/Congenital/Other Diseases
- **E72.04** Cystinosis
- **E72.53** Hyperoxaluria
- **E75.21** Fabry (-Anderson) disease
- **N07.8** Hereditary nephropathy, not elsewhere classified with other morphologic lesions
- **N31.9** Neuromuscular dysfunction of bladder, unspecified
- **Q56.0** Hermaphroditism, not elsewhere classified
- **Q60.2** Renal agenesis, unspecified
- **Q61.19** Other polycystic kidney, infantile type
- **Q61.2** Polycystic kidney, adult type
- **Q61.4** Renal dysplasia
- **Q61.5** Medullary cystic kidney
- **Q61.8** Other cystic kidney diseases
- **Q62.11** Congenital occlusion of ureteropelvic junction
- **Q62.12** Congenital occlusion of ureterovesical orifice
- **Q63.8** Other specified congenital malformations of kidney
- **Q64.2** Congenital posterior urethral valves
- **Q79.4** Prune belly syndrome
- **Q85.1** Tuberous sclerosis
- **Q86.8** Other congenital malformation syndromes due to known exogenous causes
- **Q87.1** Congenital malformation syndromes predominantly associated with short stature
- **Q87.81** Alport syndrome

## Neoplasms/Tumors
- **C64.9** Malignant neoplasm of unspecified kidney, except renal pelvis
- **C80.1** Malignant (primary) neoplasm, unspecified
- **C85.93** Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
- **C88.2** Heavy chain disease
- **C90.00** Multiple myeloma not having achieved remission
- **D30.9** Benign neoplasm of urinary organ, unspecified
- **D41.00** Neoplasm of uncertain behavior of unspecified kidney
- **D41.9** Neoplasm of uncertain behavior of unspecified urinary organ
- **E85.9** Amyloidosis, unspecified

## Disorders of Mineral Metabolism
- **E83.52** Hypercalcemia

## Genitourinary System
- **A18.10** Tuberculosis of genitourinary system, unspecified
- **N28.9** Disorder of kidney and ureter, unspecified

## Acute Kidney Failure
- **N17.0** Acute kidney failure with tubular necrosis
- **N17.1** Acute kidney failure with acute cortical necrosis
- **N17.9** Acute kidney failure, unspecified

## Miscellaneous Conditions
- **B20** Human immunodeficiency virus [HIV] disease
- **D57.1** Sickle-cell disease without crisis
- **D57.3** Sickle cell trait
- **I50.9** Heart failure, unspecified
- **K76.7** Hepatorenal syndrome
- **M10.30** Gout due to renal impairment, unspecified site
- **N14.0** Analgesic nephropathy
- **N14.1** Nephropathy induced by other drugs, medicaments and biological substances
- **N14.3** Nephropathy induced by heavy metals
- **N20.0** Calculus of kidney
- **N25.89** Other disorders resulting from impaired renal tubular function
- **N26.9** Renal sclerosis, unspecified
- **N28.0** Ischemia and infarction of kidney
- **N28.89** Other specified disorders of kidney and ureter
- **O90.4** Postpartum acute kidney failure
- **S37.009A** Unspecified injury of unspecified kidney, initial encounter
- **Z90.5** Acquired Absence of Kidney
ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. PATIENT'S LAST NAME
2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S COUNTY OF RESIDENCE
4. STATE
5. DATE OF BIRTH
6. DATE OF DEATH

7. PROVIDER NAME AND ADDRESS (CITY AND STATE)

8. PROVIDER NUMBER
9. PLACE OF DEATH (Check one)

10. WAS AN AUTOPSY PERFORMED?

11. CAUSES OF DEATH (Place number from the List of Causes in the spaces provided).

Primary Cause
Secondary Causes

LIST OF CAUSES

01 Pericarditis
(Including cardiaco tamponade)

02 Myocardial infarction, acute

03 Cardiac (Other than 01 or 02)

04 Cerebrovascular
(Including spontaneous subdural hematoma)

05 Embolism, air

06 Embolism, pulmonary

07 GI hemorrhage

08 Vascular access hemorrhage

09 Hemorrhage (Other than 04, 07, or 08)

10 Pulmonary infection

11 Septicemia

12 Viral hepatitis

13 Infection (Other than 10, 11, 12)

14 Hyperkalemia

15 Pancreatitis

16 Malignancy

17 Withdrawal from dialysis

18 Suicide

19 Accidental death, treatment related

(Other than 05)

20 Accidental death not treatment related

21 Unknown cause

22 Other (Specify in Remarks)

12. IF A MALIGNANCY WAS PRESENT AT DEATH, INDICATE THE YEAR DIAGNOSED, SITE AND TYPE OF EACH PRIMARY.

1. __________ Yr. __________ Site __________ Type __________

2. __________ Yr. __________ Site __________ Type __________

13. IF DECEASED RECEIVED A TRANSPLANT

1. Date of most recent transplant

2. Was kidney functioning (Patient off dialysis) prior to death?

1 □ Yes 2 □ No 3 □ Unknown

3. Did transplant patient resume outpatient chronic maintenance dialysis prior to death?

1 □ Yes 2 □ No

REMARKS

SIGNATURE DATE

NOTE: *If patient residence is not in a specific county, enter incorporated city or township.

Under provisions of the Privacy Act 1974, P.L. 93-579, amending Title 5, United States Code, the information collected herein is not being used for any purpose other than to accommodate the renal provisions of P.L. 92-603.

Form E0A-905 (6/76)
### ESRD DEATH NOTIFICATION

**END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 17 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

<table>
<thead>
<tr>
<th>1. PATIENT'S LAST NAME</th>
<th>FIRST</th>
<th>MI</th>
<th>2. HEALTH INSURANCE CLAIM NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT'S SEX</th>
<th>4. PATIENT'S STATE OF RESIDENCE</th>
<th>5. DATE OF BIRTH</th>
<th>6. DATE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Male</td>
<td>b. Female</td>
<td>MONTH</td>
<td>DAY</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>7. PROVIDER NAME AND ADDRESS (CITY AND STATE)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. PROVIDER NUMBER</th>
<th>9. PLACE OF DEATH (Check one)</th>
<th>10. WAS AN AUTOPSY PERFORMED?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11. CAUSES OF DEATH (Enter code from List of Causes below.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary Cause</td>
</tr>
</tbody>
</table>

#### LIST OF CAUSES

**CARDIAC**
- 23 Myocardial infarction, acute
- 24 Hypertension
- 25 Pericarditis, incl. cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid

**VASCULAR**
- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39 or 41)
- 43 Other hemorrhage (not Codes 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

**INFECTION**
- 49 Septicemia, due to vascular access
- 50 Septicemia, due to peritonitis
- 51 Septicemia, due to peripheral vascular disease, gangrene
- 52 Septicemia, other
- 53 Pulmonary infection (bacterial)
- 54 Pulmonary infection (fungal)
- 55 Pulmonary infection (other)
- 56 Viral infection, CMV
- 57 Viral infection, Other (not 64 or 65)
- 58 Tuberculosis
- 59 A.I.D.S.
- 60 Infections, other

**LIVER DISEASE**
- 64 Hepatitis B
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown other

**GASTRO-INTESTINAL (see also 50)**
- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 74 Fungal peritonitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

**OTHER**
- 80 Bone marrow depression
- 81 Cachexia
- 82 Malignant disease, patient ever on immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 86 Diabetic coma, hyperglycemia, hypoglycemia
- 87 Chronic obstructive lung disease (COPD)
- 88 Complications of surgery
- 89 Air embolism
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 95 Other identified cause of death, please specify:

<table>
<thead>
<tr>
<th>12. FOR ALL DEATHS INDICATE YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal replacement therapy discontinued prior to death:</td>
</tr>
</tbody>
</table>

If Yes, check one of the following:
- a. Following HD and/or PD access failure
- b. Following transplant failure
- c. Following chronic failure to thrive

<table>
<thead>
<tr>
<th>13. IF DECEASED RECEIVED A TRANSPLANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Date of most recent transplant</td>
</tr>
</tbody>
</table>

If transplant was received:
- b. Was kidney functioning (patient not on dialysis) at time of death?
- c. Did transplant patient resume chronic maintenance dialysis prior to death?

<table>
<thead>
<tr>
<th>14. REMARKS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>15. NAME OF PHYSICIAN</th>
<th>16. SIGNATURE OF PERSON COMPLETING THIS FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DATE</td>
</tr>
</tbody>
</table>

**ESRD DEATH NOTIFICATION**

**END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM**

1. Patient's Last Name  
First  
MI  
2. Medicare Claim Number

3. Patient’s Sex  
a. ☐ Male  
b. ☐ Female

4. Date of Birth 
   - _ _ / _ _ / _ _ _ _
   Month  Day  Year

5. Social Security Number

6. Patient's State of Residence  
a. ☐ Hospital  
b. ☐ Dialysis Unit  
c. ☐ Home  
d. ☐ Nursing Home  
e. ☐ Other

7. Place of Death  
a. ☐ Hospital  
b. ☐ Home  
c. ☐ Other  

8. Date of Death 
   - _ _ / _ _ / _ _ _ _
   Month  Day  Year

9. Modality at Time of Death  
a. ☐ Incenter Hemodialysis  
b. ☐ Home Hemodialysis  
c. ☐ CAPD  
d. ☐ CCPD  
e. ☐ Transplant  
f. ☐ Other

10. Provider Name and Address (Street)

Provider Address (City/State)

11. Provider Number

12. Causes of Death (enter codes from list on back of form)
   a. Primary Cause  _ _ _
   b. Were there secondary causes?  
      ☐ No  
      ☐ Yes, specify:  _ _ _  _ _ _  _ _ _  _ _ _
   C. If cause is other (98) please specify:  

13. Renal replacement therapy discontinued prior to death:  ☐ Yes  ☐ No

   If yes, check one of the following:
   a. ☐ Following HD and/or PD access failure  
   b. ☐ Following transplant failure  
   c. ☐ Following chronic failure to thrive  
   d. ☐ Following acute medical complication  
   e. ☐ Other  
   f. Date of last dialysis treatment  - _ _ / _ _ / _ _ _ _
      Month  Day  Year

14. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?  
   ☐ Yes  ☐ No

   ☐ Unknown  ☐ Not Applicable

15. If deceased ever received a transplant:  
   a. Date of most recent transplant  - _ _ / _ _ / _ _ _ _  ☐ Unknown  
      Month  Day  Year
   b. Type of transplant received  
      ☐ Living Related  ☐ Living Unrelated  ☐ Deceased  ☐ Unknown
   c. Was graft functioning (patient not on dialysis) at time of death?  
      ☐ Yes  ☐ No  ☐ Unknown
   d. Did transplant patient resume chronic maintenance dialysis prior to death?  
      ☐ Yes  ☐ No  ☐ Unknown

16. Was patient receiving Hospice care prior to death?  
   ☐ Yes  ☐ No

   ☐ Unknown

17. Name of Physician (Please print complete name)

18. Signature of Person Completing This Form  
Date

---

# ESRD DEATH NOTIFICATION FORM
## LIST OF CAUSES

### CARDIAC
- 23 Myocardial infarction, acute
- 25 Pericarditis, incl. Cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid
- 32 Congestive Heart Failure

### PERICARDITIS, INCL. CARDIAC TAMPOONADE

### LIVER DISEASE
- 64 Hepatitis B
- 71 Hepatitis C
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown or other

### VASCULAR
- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39, or 41)
- 43 Other hemorrhage (not 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

### INFECTION
- 33 Septicemia due to internal vascular access
- 34 Septicemia due to vascular access catheter
- 35 Peritoneal access infectious complication, bacterial
- 36 Peritoneal access infectious complication, fungal
- 37 Peritonitis (complication of peritoneal dialysis)
- 38 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
- 39 Septicemia due to peripheral vascular disease, gangrene
- 40 Septicemia, other
- 41 Cardiac infection (endocarditis)
- 42 Pulmonary infection (pneumonia, influenza)
- 43 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
- 44 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

### GASTRO-INTESTINAL
- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

### INFECTION
- 45 Peritoneal access infectious complication, bacterial
- 46 Peritoneal access infectious complication, fungal
- 47 Peritonitis (complication of peritoneal dialysis)
- 48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
- 49 Septicemia due to peripheral vascular disease, gangrene
- 50 Septicemia, other
- 51 Cardiac infection (endocarditis)
- 52 Pulmonary infection (pneumonia, influenza)
- 53 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
- 54 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

### METABOLIC
- 24 Hyperkalemia
- 77 Hypokalemia
- 78 Hypernatremia
- 79 Hyponatremia
- 100 Hypoglycemia
- 101 Hyperglycemia
- 102 Diabetic coma
- 95 Acidosis

### ENDOCRINE
- 96 Adrenal insufficiency
- 97 Hypothyroidism
- 103 Hyperthyroidism

### OTHER
- 80 Bone marrow depression
- 81 Cachexia/failure to thrive
- 82 Malignant disease, patient ever on Immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 86 Chronic obstructive lung disease (COPD)
- 87 Complications of surgery
- 88 Air embolism
- 104 Withdrawal from dialysis/uremia
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 98 Other cause of death
- 99 Unknown

---

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## DIALYSIS PATIENTS

### Additions During Survey Period

<table>
<thead>
<tr>
<th>Field</th>
<th>Outpatient</th>
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<th>Total</th>
<th>Fields 01 thru 02</th>
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### Losses During Survey Period

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<th>Home</th>
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### Patients Receiving Care at End of Survey Period

<table>
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<th>Field</th>
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<th>Home</th>
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<th>Total Patients</th>
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### Transient Patients

<table>
<thead>
<tr>
<th>Field</th>
<th>Self-Dialysis Completing Training</th>
<th>Treated during survey period</th>
<th>Number of outpatient treatments during survey period</th>
</tr>
</thead>
<tbody>
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### Patient Eligibility Status

<table>
<thead>
<tr>
<th>Field</th>
<th>Currently enrolled in Medicare</th>
<th>Medicare application pending</th>
<th>Non-Medicare</th>
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<tbody>
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<td>27</td>
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<tr>
<td>29</td>
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</tbody>
</table>

### Outpatient Dialysis Treatments

- Hemodialysis
- IPD

### Dialysis Training Treatments

- Hemodialysis
- IPD
- CAPD
- CCPD

**Remarks Regarding Information Provided on This Survey Should Be Entered on the Last Page of the Survey**

This report is required by law (42 USC 426; 42, CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 5520; 45 CFR, Part 5a).
PART TWO — KIDNEY TRANSPLANTS

PATIENTS TRANSPLANTED AND DONOR TYPE

<table>
<thead>
<tr>
<th>Patients who received transplant at this facility</th>
<th>Eligibility Status of Patients Transplanted at this Facility During the Survey Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Currently enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>Medicare application pending</td>
</tr>
<tr>
<td></td>
<td>Non-Medicare U.S. Res. Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Transplants Performed at This Facility</th>
<th>Patients Awaiting Transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Related Donor</td>
<td>Living Unrelated Donor</td>
</tr>
<tr>
<td>47</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cadaver Kidneys Source of Cadaver Kidneys</th>
<th>Disposition of Cadaver Kidneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplanted at this facility</td>
<td>Sent to another U.S. facility</td>
</tr>
<tr>
<td>Sent Outside the U.S.</td>
<td>Non-Viable Kidneys</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
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</tbody>
</table>

SKIP THIS SECTION

Harvested at this center

Obtained from another transplant hospital

Obtained from Independent OPOs

Obtained from Non-transplant hospital

Total

<table>
<thead>
<tr>
<th>Total Non-Viable Kidneys</th>
<th>Used for Research</th>
<th>Discarded</th>
<th>Total</th>
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<tbody>
<tr>
<td>77</td>
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</tbody>
</table>

COMPLETED BY (Signature)       DATE       TITLE

VERIFIED BY (Signature)        DATE       TITLE

REMARKS REGARDING INFORMATION PROVIDED ON THIS SURVEY SHOULD BE ENTERED ON THE LAST PAGE OF THE SURVEY

This report is required by law (42 USC 426; 42, CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 552a; 45 CFR, Part 5a).
PART THREE

REMARKS

According to the Paperwork Reduction Act of 1995, no persons are required to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0447. This time required to complete this information collection is estimated to average 8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

COMPLETED BY (Signature) DATE TITLE

VERIFIED BY (Signature) DATE TITLE

REMARKS REGARDING INFORMATION PROVIDED ON THIS SURVEY SHOULD BE ENTERED ON THIS PAGE OF THE SURVEY

This report is required by law (42 USC 426; 42, CFR 405.2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 USC 552a; 45 CFR, Part 5a).

Form HCFA-2744 (11-88) Department of Health and Human Services
Health Care Financing Administration
ESRD FACILITY SURVEY
(HCFA-2744)
INSTRUCTIONS FOR COMPLETION

REPORTING RESPONSIBILITY
The ESRD Facility Survey is designed to capture only a limited amount of information concerning each Federally approved renal facility's operation. It is not intended to yield information on the full range of ancillary services or activities, e.g., referrals, graft outcome, etc. These concerns are more appropriately and validly addressed by the network in supplemental requests or through other segments of the Program Management and Medical Information System.

Every facility/center approved by Medicare to provide services to ESRD patients must furnish the information requested in the ESRD Facility Survey (42 U.S.C. 426; 20 CFR 405, Section 2133). It is also the facility's/center's responsibility to provide patient and treatment counts to their local ESRD Network upon termination of operations. Facilities certified as only providing inpatient services are not requested to complete a survey.

Survey Period
The Facility Survey is completed annually. The survey period is January 1 through December 31. This Facility Survey is to be completed for the period January 1, 2001 through December 31, 2001. Unless specified otherwise, all data entered on the Facility Survey is to cover the entire survey period. The form should be completed and forwarded to the local ESRD Network.

GENERAL INSTRUCTIONS
For purposes of this document, the word “facility” will be used interchangeably when referring to renal dialysis facilities, renal dialysis centers, or renal transplant centers, as applicable.

All patient and treatment counts requested are to include only the diagnosed chronic ESRD population; no reversible failure patients or treatments may be counted.

All diagnosed chronic ESRD patients treated at the facility should be counted and reported as (1) regular, continuing caseload (field 03); (2) added to the regular caseload (fields 04A through 07B); (3) lost from the regular caseload (fields 08A through 13B); or (4) transient (field 34).

Inclusion of patients in counts should not depend on entitlement determination; newly diagnosed chronic unit admissions should be included, both for peritoneal or hemodialytic therapy and transplantation.

NOTE: Any provider who has signed an agreement with a dialysis supplier to provide support services to Method II home patients should count those patients as part of their regular dialysis population on the ESRD Facility Survey Form. Please keep this in mind when completing fields for home dialysis patients.
PART ONE-DIALYSIS

( FOR COMPLETION BY DIALYSIS UNITS ONLY )

PATIENT LOAD

Patients Receiving Care Beginning of Survey Period

Field 01: Outpatient. Enter the number of patients dialyzing in your facility at the beginning of the survey period. This number should reflect your “permanent” patient population; i.e., those patients for whom your facility had ongoing medical responsibility for the routine care of the patient until he/she was formally transferred elsewhere. Include those of your routine patients who were hospitalized or were in transient status away from your facility at the beginning of the survey period. This number should be the same as that reported in field 20 from the previous survey submitted.

Field 02: Home. Enter the number of patients followed by your facility; that is, for whom your facility had the major medical responsibility (e.g., the facility which provides outpatient backup dialysis, performs necessary medical follow-ups, provides the patient with home dialysis supplies, or has a written agreement to provide support services to Method II patients). Enter the number of patients who were dialyzing at home (hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, or continuous cycling peritoneal dialysis) at the beginning of the survey period. This number should be the same as that reported in field 25 from the previous survey submitted.

Field 03: Total. Enter the sum of fields 01 and 02. This should equal the number of patients on your facility’s register at the beginning of the survey period and should be the same as that reported in field 26 from the previous survey submitted.

Additions During the Survey Period

NOTE: This section requires counts for additional outpatient and home dialysis patients accepted during the survey period. A PATIENT SHOULD NOT BE COUNTED IN MORE THAN ONE FIELD (fields 04A through 07B). If more than one field is applicable, count the patient in the field which describes the first time the patient started or returned to dialysis at your facility during the year.

Newly Diagnosed Patients

Field 04A: Outpatient—Started for the First Time Ever. Enter the number of newly diagnosed ESRD patients who were admitted to your facility as chronic maintenance dialysis patients for the first time ever during the survey period. This is a count of patients who have begun their initial course of outpatient maintenance dialysis therapy during the survey period and for whom your facility will have major medical responsibility. Do not include patients who transferred to your facility from another dialysis facility; that data is to be reported in field 06A. Include in field 04A patients who began their initial course of maintenance dialysis therapy at a non-approved renal provider and transferred to your facility during the survey period. (That is, patients who were stabilized and then transferred to you.)

Field 04B: Home—Started for the First Time Ever. Enter the number of newly diagnosed ESRD patients who, after being stabilized on dialysis, successfully completed a course of self-dialysis training and began home dialysis (their initial course of home dialysis after training) during the survey period. If they are still in training at the end of the survey period, report them in field 04A.

Restarted Dialysis

Field 05A: Outpatient—Restarted. Enter the number of patients who restarted outpatient dialysis during the survey period. This is a count of persons who had temporarily recovered kidney function, had discontinued dialysis, or had been lost to follow-up but restarted routine outpatient dialysis during the survey period.

Field 05B: Home—Restarted. Enter the number of patients who restarted home dialysis during the survey period. This is a count of patients who had temporarily recovered kidney function, had discontinued dialysis, or had been lost to follow-up but restarted regular home dialysis during the survey period.

Transferred From Another Facility

Field 06A: Outpatient—Transferred from Other Dialysis Unit. Enter the number of patients admitted to your facility who were formally transferred from another dialysis facility during the survey period and who are continuing a regular course of dialysis at your facility. A formal transfer is the transfer of a patient, including his/her medical records, to another facility who will permanently become the primary care provider.
Field 06B: Home—Transferred from Other Dialysis Unit. Enter the number of home patients who were formally transferred by another facility during the survey period to your unit for ongoing medical supervision and responsibility. A formal transfer is the transfer of a patient, including his/her medical records, to another facility who will permanently become the primary care provider.

Returned After Transplantation

Field 07A: Outpatient—Returned After Transplantation. Enter the number of patients who returned to outpatient dialysis during the survey period after a transplant failure.

Field 07B: Home—Returned After Transplantation. Enter the number of patients who returned to home dialysis during the survey period after a transplant failure.

Losses During the Survey Period

NOTE: These fields describe losses to your facility of both outpatient and home patients that occurred during the survey period. For purposes of this survey, “outpatient” includes patients who routinely dialyzed as an outpatient at the time of loss to the reporting facility, and “home” includes patients who routinely dialyzed at home at the time of loss to the reporting facility. A PATIENT SHOULD NOT BE COUNTED IN MORE THAN ONE FIELD (08A through 13B). If more than one field is applicable, count the patient in the field which describes the status the last time the patient stopped dialyzing at your facility during the year, or the last known status of the patient.

Deaths

Field 08A: Outpatient—Deaths. Enter the number of outpatient dialysis patients who died during the survey period. (These deaths must be shown here by the facility if the patients were reported in fields 01, 04A, 05A, 06A, or 07A.)

Field 08B: Home—Deaths. Enter the number of home dialysis patients who died during the survey period. (These deaths must be shown here by the facility if the patients were reported in fields 02, 04B, 05B, 06B, or 07B.)

Recovered Kidney Function

NOTE: These are diagnosed chronic renal failure patients who recovered renal function. Count patients who had been on dialysis for 45 days or more and were alive and not requiring any form of dialytic therapy or transplantation.

Field 09A: Outpatient—Recovered Kidney Function. Enter the number of patients who recovered kidney function and ceased chronic outpatient dialysis during the survey period.

Field 09B: Home—Recovered Kidney Function. Enter the number of patients who recovered kidney function and ceased chronic home dialysis during the survey period.

Transplanted

Field 10A: Outpatient—Received Transplant. Enter the number of patients who received a kidney transplant and left the outpatient dialysis program during the survey period.

Field 10B: Home—Received Transplant. Enter the number of patients who received a kidney transplant and left the home dialysis program during the survey period.

Transferred Out

Field 11A: Outpatient—Transferred to Other Dialysis Unit. Enter the number of in-unit dialysis patients who permanently transferred to another dialysis facility for their ongoing dialysis during the survey period; that is, those patients whose ongoing, routine medical supervision became the responsibility of another dialysis facility.

Field 11B: Home—Transferred to Other Dialysis Unit. Enter the number of home patients who had been followed by your facility but who are now permanently followed by another home dialysis program.

Discontinued Dialysis

NOTE: These fields should contain counts of patients whose last known activity was that they discontinued dialysis. This would pertain mostly to patients who were lost to the facility at the end of the sur-
vey period, were not lost to follow-up and had not yet expired by December 31 (a Death Notification Form has not yet been submitted on the patient).

**Field 12A: Outpatient—Discontinued Dialysis.** Enter the number of chronic patients who permanently discontinued dialysis (excluding those reported in fields 08A, 09A, 10A and 11A) who had been dialyzing outpatient during the survey period.

**Field 12B: Home—Discontinued Dialysis.** Enter the number of chronic patients who permanently discontinued dialysis (excluding those reported in fields 08B, 09B, 10B, and 11B) who had been dialyzing at home during the survey period.

**Lost to Follow-Up**

**Field 13A: Outpatient—Lost to Follow-Up (LTFU).** Enter the number of patients, who had been dialyzing as an outpatient, who left your dialysis program during the survey period, and whose current status is unknown to your facility (lost to follow-up). Do not include those reported in fields 08A, 09A, 10A, or 12A.

**Field 13B: Home—Lost to Follow-Up (LTFU).** Enter the number of patients, followed by your facility, who had been dialyzing at home, who were removed from your facility's rolls during the survey period, and whose current status is unknown (lost to follow-up). Do not include those reported in fields 08B, 09B, 10B, 11B, or 12B.

**Patients Receiving Care at the End of the Survey Period**

**NOTE:** DO NOT COUNT A PATIENT IN MORE THAN ONE FIELD. Patients receiving care at the beginning of the survey period plus the additions during the survey period minus the losses during the survey period should equal the patients receiving care (remaining) at the end of the survey period. Please ensure that field 03 plus field 04A through 07B, minus fields 08A through 13B, equals field 26.

**Outpatient Dialysis**

**NOTE:** Patients who are dialyzing as outpatients, but are performing all dialysis procedures without the assistance of staff, are to be counted as outpatients self-dialyzing either in fields 14 or 15. (Since this is not a large patient population, not all facilities will have patients that fall into this category.) Treatments for these patients should be counted as outpatient treatments in fields 36 or 37.

**Field 14: Hemodialysis.** Enter the number of patients who, at the end of the survey period, were receiving staff-assisted hemodialysis or performing outpatient self hemodialysis.

**Field 15: Peritoneal Dialysis.** Enter the number of patients who, at the end of the survey period, were receiving staff-assisted intermittent peritoneal dialysis or performing outpatient self peritoneal dialysis.

**Self-Dialysis Training**

**Field 16: Hemodialysis.** Enter the number of patients who are in a self hemodialysis training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to perform their own self-dialysis as an outpatient or at home.

**Field 17: Peritoneal Dialysis.** Enter the number of patients who are in a self intermittent peritoneal dialysis training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to perform their own self-dialysis as an outpatient or at home.

**Field 18: Continuous Ambulatory Peritoneal Dialysis (CAPD).** Enter the number of patients who are in a CAPD training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to independently perform CAPD.

**Field 19: Continuous Cycling Peritoneal Dialysis (CCPD).** Enter the number of patients who are in a CCPD training program as of the end of the survey period. Patients are to be reported in this category only if the training is designed to enable them to independently perform CCPD.

**Field 20: Total Outpatient.** Enter the total number of patients who are in outpatient status as of the end of the survey period (the sum of fields 14 through 19).
Home Dialysis

NOTE: Patients who are dialyzing at home with the assistance of staff provided by a dialysis supplier or facility should be counted as home patients (fields 21 through 24).

**Field 21: Hemodialysis.** Enter the number of patients who were hemodialyzing at home as of the end of the survey period.

**Field 22: Peritoneal Dialysis.** Enter the number of patients who are on home intermittent peritoneal dialysis as of the end of the survey period.

**Field 23: Continuous Ambulatory Peritoneal Dialysis (CAPD).** Enter the number of patients who are on CAPD as of the end of the survey period.

**Field 24: Continuous Cycling Peritoneal Dialysis (CCPD).** Enter the number of patients who are on CCPD as of the end of the survey period.

**Field 25: Total Home.** Enter the total number of patients who are in home status as of the end of the survey period (the sum of fields 21 through 24).

**Total**

**Field 26: Total.** Enter the total number of patients on your facility’s register at the end of the survey period (the sum of fields 20 and 25).

Patient Eligibility Status—End of Survey Period

NOTE: Counts should reflect entitlement only, not based on how reimbursement is made for dialysis services provided by your facility. For example, a VA (Department of Veterans Affairs) patient whose reimbursement is made by the VA, but is a Medicare entitled patient, should be counted in Field 27. Please ensure that the sum of fields 27, 28, and 29 equals field 26, the total number of patients at the facility at the end of the survey period.

**Field 27: Currently Enrolled in Medicare.** Enter the number of patients at the end of the survey period who were enrolled in Medicare.

**Field 28: Medicare Application Pending.** Enter the number of patients at the end of the survey period who had Medicare applications pending.

**Field 29: Non-Medicare.** Enter the number of patients at the end of the survey period who were not enrolled in Medicare and who did not have Medicare applications pending.

Self Dialysis Patients Completing Training

NOTE: This section is a non-add, non-subtract count for caseload purposes only. The following section (fields 30 through 33) should be completed only by those facilities that have self-care training programs. Included in this section will be the number of patients who, during the survey period, successfully completed a course of self-dialysis training at the reporting facility which enabled them to self-dialyze as an outpatient or at home. Patients who were still in a self-dialysis training course on the last day of the survey period are not to be counted in these fields; that data is to be reported in fields 16 through 19. Unsuccessful trainees (those who did not go home or initiate self-care in a facility) are not to be counted here. (This count is a non-add, non-subtract count for caseload purposes.) DO NOT INCLUDE PATIENTS WHO WERE TRANSFERRED TO ANOTHER FACILITY FOR SELF-CARE TRAINING NOR THOSE PATIENTS RETRAINED IN SELF-CARE DIALYSIS DURING THE SURVEY PERIOD. (For example: If a self-hemodialysis patient is retrained for self-hemodialysis, do not count this patient as completing self-hemodialysis, but count this patient if they trained in a different modality.)

**Field 30: Hemodialysis.** Enter the number of patients who, during the survey period, successfully completed a course of training for home or outpatient self-hemodialysis at your facility.

**Field 31: IPD (Intermittent Peritoneal Dialysis).** Enter the number of patients who, during the survey period, successfully completed a course of training for home or outpatient self-peritoneal dialysis at your facility.

**Field 32: CAPD.** Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for continuous ambulatory peritoneal dialysis at your facility.
Field 33: CCPD. Enter the number of patients who, during the survey period, successfully completed a course of self-dialysis training for continuous cycling peritoneal dialysis at your facility.

Transient Patients

NOTE: Transient patients are those patients that your facility treats/supervises on an episodic basis; that is, treats the patient for less that 6 months continuous or less than 51 percent of the year. Those patients who are treated for 6 months or more or more than 51 percent of the year are counted as part of the regular patient caseload (field 26). Please note that the 6 month/51 percent rule does not apply to permanent transfers.

Field 34: Transient Outpatients—Treated During Survey Period. Enter the number of transient outpatients who received care at your facility during the survey period. This field is a count of patients, not episodes of treatment. Therefore, if a patient is treated at a facility in February and again at that same facility in August, he/she is counted only once.

Field 35: Transient Patients—Number of Outpatient Treatments During Survey Period. Using the definition of “transient patient” given above, enter the number of transient outpatient dialysis treatments (all dialysis settings) given during the survey period. Be sure to include these treatments in the appropriate modality under treatment load (fields 36 and 37). If transient patients are reported in field 34, you must enter the number of treatments that were provided.

TREATMENT LOAD

NOTE: The following section (fields 36 and 37) should reflect only outpatient treatments given to ESRD patients. Self-care training treatments should be reported only in fields 38 through 41. All such treatments, including those provided to transients, should be reported in fields 36 through 41, where appropriate. Please be certain to report treatments to correspond with patients counted at the end of the survey period in a particular modality. If a situation occurs where a patient is reported at the end of the survey period but no treatments were provided, please explain why no treatments were provided in the Remarks section of the survey form. DO NOT INCLUDE ACUTE TREATMENTS.

Hemodialysis

Field 36: Outpatient Treatments. Enter the number of staff-assisted hemodialysis treatments provided and the number of treatments performed by self dialyzing patients on an outpatient basis during the survey period.

IPD

Field 37: Outpatient Treatments. Enter the number of staff-assisted intermittent peritoneal treatments provided and the number of treatments performed by self dialyzing patients on an outpatient basis during the survey period.

Self-Care Training Treatments

NOTE: For all types of peritoneal dialysis training, report the number of days for which exchanges were provided. Do not report the number of exchanges and do not report days where no dialysis treatments or exchanges were furnished.

Self-care training treatments should not be included in fields 36 and 37. If you report patients completing self-dialysis training, you must report the number of treatments/days corresponding to the modality of training provided. These treatments should be counted for those patients completing training in a modality for the first time. For example, if a patient who has been on self-hemodialysis receives training for CAPD, those CAPD days of training are counted in field 40. If a self-hemodialysis patient is retrained for self hemodialysis, do not count those treatments. Include, in the appropriate field, the number of treatment/days provided to patients who were receiving self-care training at the end of the survey period and were reported in fields 16 through 19. Include all training treatments/days provided whether the patient has completed self-care training or not. Only count treatments for which dialysis was actually given. Do not include training to dialysis aides, etc. Please keep this in mind especially when reporting training for pediatric patients.

Field 38: Hemodialysis. Enter the number of hemodialysis training treatments given during the survey period.

Field 39: IPD. Enter the number of intermittent peritoneal dialysis training treatments given during the survey period.
Field 40: CAPD. Enter the number of continuous ambulatory peritoneal dialysis training treatments given during the survey period.

Field 41: CCPD. Enter the number of continuous cycling peritoneal dialysis training treatments given during the survey period.

Signatures
Part One of the Facility Survey requires signatures, as follows:

Completed by: Enter the date completed and the name, title, and telephone number of the person who completed the Facility Survey for your facility. This person should be the individual who the ESRD network or HCFA can contact to discuss any information provided in the Facility Survey.

Verified by: Enter the date and the signature and title of the facility’s renal administrator.

PART TWO-KIDNEY TRANSPLANTS
(For completion by kidney transplant facilities)

PATIENTS/TRANSPLANTS

Field 42: Patients Who Received Transplant at This Facility. Enter the number of patients who received a kidney transplant at your facility during the survey period. If a patient received more than one transplant at your center during the survey period, the patient is to be counted only once. Total of fields 43 + 44 + 45 + 46.

Patient Eligibility Status of Patients Transplanted During Survey Period.
Fields 43 through 46 refer to those patients actually transplanted during the survey period. Ensure that the total of fields 43 through 46 equals the count in field 42.

Field 43: Currently Enrolled in Medicare. Enter the number of patients transplanted during the survey period who were enrolled in Medicare. Count Medicare transplant recipients based on enrollment rather than primary insurer.

Field 44: Medicare Application Pending. Enter the number of patients transplanted during the survey period who had Medicare applications pending.

Field 45: Non-Medicare, U.S. Residents. Enter the number of patients transplanted during the survey period who were not enrolled in Medicare and did not have Medicare applications pending who were either U.S. citizens or a foreign national U.S. resident.

Field 46: Non-Medicare, Other. Enter the number of patients transplanted during the survey period who were not enrolled in Medicare, did not have Medicare applications pending, and were neither a U.S. citizen nor a U.S. resident (e.g., foreign national).

Transplants Performed at This Facility

Field 47: Transplants Performed at This Facility—Living Related Donor. Enter the number of living related donor kidney transplants performed at your center during the survey period.

Field 48: Transplants Performed at This Facility—Living Unrelated Donor. Enter the number of living unrelated donor kidney transplants performed at your center during the survey period.

Field 49: Transplants Performed at This Facility—Cadaveric Donor. Enter the number of cadaveric donor kidney transplants performed at your center during the survey period.

Field 50: Transplants Performed at This Facility—Total Fields 47 and 48. Enter the sum of fields 47 + 48 + 49.

Patients Awaiting Transplant

Field 51: Patients Awaiting Transplant—Dialysis. Enter the number of current dialysis patients actively awaiting a kidney transplant at your center as of the last day of the survey period. These patients must (a) be medically able, (b) have given consent, and (c) be on an active transplant list. This count is limited to individuals awaiting transplant at the reporting center.
Field 52: Patients Awaiting Transplant-Non—Dialysis. Following the criteria described above, enter the number of non-dialysis patients who are awaiting transplant as of the last day of the survey period. This is to include patients scheduled for transplant who have not yet initiated a regular course of dialysis.

DISPOSITION OF CADAVER KIDNEYS
PLEASE SKIP THIS PORTION OF THE FORM. KIDNEY TRANSPLANT CENTERS ARE NOT REQUIRED TO COMPLETE THIS SECTION OF THE FORM FOR THE 2001 SURVEY PROCESS.

Signatures
Part Two of the Facility Survey requires signatures as follows:

Completed by: Enter the date completed and the name, title and telephone number of the person who completed the Facility Survey for your facility. This person should be the individual who the ESRD network or HCFA can contact.

Verified by: Enter the date verified and the signature and title of the facility's renal administrator.

PART THREE - REMARKS
You may include here any remarks or additional information you wish to supply concerning the information furnished on this survey.
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Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, defend and indemnify any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

This is to certify that:

(a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

(b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

(c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

(d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

(e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

(f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

(g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

(h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.
**HEALTH INSURANCE CLAIM FORM**

<table>
<thead>
<tr>
<th>Column</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Medicare, Medicaid, CHAMPUS, CHAMPVA, Group Health Plan, FECA, Other</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Date of Birth (MM DD YY)</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Insured's I.D. Number (For program in Item 1)</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Insured's Policy Group or FECA Number</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>Insured's Date of Birth</td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td>Employer's Name or School Name</td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td><strong>10.</strong></td>
<td>Insured's Relationship to Insured</td>
</tr>
<tr>
<td><strong>11.</strong></td>
<td>Insured's Date of Birth (MM DD YY)</td>
</tr>
<tr>
<td><strong>12.</strong></td>
<td>Patient's Signature</td>
</tr>
<tr>
<td><strong>13.</strong></td>
<td>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
<tr>
<td><strong>14.</strong></td>
<td>Date of Current Illness or Injury (MM DD YY)</td>
</tr>
<tr>
<td><strong>15.</strong></td>
<td>If Patient Has Had Same or Similar Illness, Give First Date (MM DD YY)</td>
</tr>
<tr>
<td><strong>16.</strong></td>
<td>Dates Patient Unable to Work in Current Occupation (MM DD YY)</td>
</tr>
<tr>
<td><strong>17.</strong></td>
<td>Name of Referring Physician or Other Source (MM DD YY)</td>
</tr>
<tr>
<td><strong>18.</strong></td>
<td>Hospitalization Dates Related to Current Services (MM DD YY)</td>
</tr>
<tr>
<td><strong>19.</strong></td>
<td>Reserved for Local Use</td>
</tr>
<tr>
<td><strong>20.</strong></td>
<td>Outside Lab?</td>
</tr>
<tr>
<td><strong>21.</strong></td>
<td>Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4 to Item 24E by Line)</td>
</tr>
<tr>
<td><strong>22.</strong></td>
<td>Medicaid Resubmission Code (Original Ref. No.)</td>
</tr>
<tr>
<td><strong>23.</strong></td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td><strong>24.</strong></td>
<td>Date(s) of Service (MM DD YY)</td>
</tr>
<tr>
<td><strong>25.</strong></td>
<td>Federal Tax I.D. Number</td>
</tr>
<tr>
<td><strong>26.</strong></td>
<td>Patient's Account No.</td>
</tr>
<tr>
<td><strong>27.</strong></td>
<td>Accept Assignment?</td>
</tr>
<tr>
<td><strong>28.</strong></td>
<td>Total Charge</td>
</tr>
<tr>
<td><strong>29.</strong></td>
<td>Amount Paid</td>
</tr>
<tr>
<td><strong>30.</strong></td>
<td>Balance Due</td>
</tr>
<tr>
<td><strong>31.</strong></td>
<td>Signature of Physician or Supplier</td>
</tr>
<tr>
<td><strong>32.</strong></td>
<td>Name and Address of Facility Where Services Were Rendered (If other than home or office)</td>
</tr>
<tr>
<td><strong>33.</strong></td>
<td>Physician's, Supplier's Billing Name, Address, Zip Code &amp; Phone #</td>
</tr>
</tbody>
</table>

**PLEASE PRINT OR TYPE**

(Approved by AMA Council on Medical Service 8/88)
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient’s signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payments directly to providers through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned in “Insured”; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as “incident” to a physician’s professional service, 1) they must be rendered under the physician’s immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician’s service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of nonphysicians must be included on the physician’s bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101 et seq. and 10 USC 1079 and 1086; 5 USC 8101 et seq. and 30 USC 901 et seq.; 38 USC 613; E.O. 9397. We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101 et seq. and 10 USC 1079 and 1086; 5 USC 8101 et seq. and 30 USC 901 et seq.; 38 USC 613; E.O. 9397.

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, ‘Carrier Medicare Claims Record,’ published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.


FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPSVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom personal information is requested. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

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.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the information being submitted is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.