DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0372

ESRD BENEFICIARY SELECTION (Home Patients Only)

PLEASE READ INSTRUCTIONS ON REVERSE BEFORE COMPLETING THIS FORM

1. NAME (Last, First, Middle Initial)

2. HEALTH INSURANCE CLAIM NUMBER (Medicare Claim Number)

3. DATE OF BIRTH (month/day/year)

__ __ __ __ __ __ __ __

4. SEX
- ❑ Male
- ❑ Female

5. PROVIDER NUMBER OF FACILITY PROVIDING HOME DIALYSIS TRAINING

5A. NAME AND ADDRESS OF FACILITY PROVIDING HOME DIALYSIS TRAINING

6. PROVIDER NUMBER OF FACILITY PROVIDING HOME DIALYSIS SUPPORT SERVICES

6A. NAME AND ADDRESS OF DIALYSIS FACILITY PROVIDING SUPPORT SERVICES

7. BENEFICIARY SELECTION, CHANGE OR CANCELLATION
- ❑ Initial Selection
- ❑ Cancellation
- ❑ Routine Method Selection Change
- ❑ Method Exception (Refer to PRM, Part I-Chap. 27, §2740.2.D.) Intermediary approval required.

Reason for Exception _____

8. TYPE OF DIALYSIS (Check One)
- ❑ Hemodialysis
- ❑ CAPD
- ❑ CCPD

9. DATE HOME DIALYSIS TRAINING IS COMPLETED

10. CHECK METHOD I OR II
- ❑ METHOD I – The ESRD facility indicated in #6 will supply all the equipment, supplies, and support services necessary for me to dialyze at home.
- ❑ METHOD II – I will deal directly with one supplier for my home dialysis supplies and equipment, and my support services will be provided by the dialysis facility indicated above.

11. NAME AND ADDRESS OF THE DURABLE MEDICAL EQUIPMENT SUPPLIER THAT WILL PROVIDE THE SUPPLIES AND EQUIPMENT (Only appropriate if beneficiary chooses Method II)

12. If I have chosen Method II, by signing this form, I certify that I have only one Method II supplier. Further, I understand that if my supplier does not take assignment, Medicare will not pay anything toward my supplier's bill.

13. CHECK LOCATION WHERE HOME DIALYSIS IS PROVIDED

❑ Private Residence ❑ Skilled Nursing Facility ❑ Nursing Home

14. BENEFICIARY SIGNATURE

15. DATE BENEFICIARY SIGNS FORM (month/day/year)

16. DATE METHOD EXCEPTION TO BE EFFECTIVE (month/day/year)

(INITIAL SELECTION CHANGES, ROUTINE SELECTION CHANGES, AND CANCELLATIONS BECOME EFFECTIVE ON JANUARY 1 OF THE YEAR FOLLOWING THE YEAR IN WHICH THIS FORM IS SIGNED)

17. The dialysis facility providing the home dialysis training is responsible for supplying this form to Medicare beneficiaries who select home dialysis and for sending the white copy of the completed form to the local Part A Intermediary (both Method I and Method II selections). Blank forms are available from the Intermediary. The white copy of this form must be sent to:

THE LOCAL INTERMEDIARY
ATTN: MEDICARE PROGRAM ADMINISTRATOR

A copy of the form must also be sent to the dialysis facility providing support services and to the supplier if the beneficiary chooses Method II.

INSTRUCTIONS FOR COMPLETING THE ESRD BENEFICIARY SELECTION FORM

Centers for Medicare & Medicaid Services regulations provide two (2) ways that a Medicare beneficiary dialyzing at home can choose to have the Medicare program pay for his/her dialysis care (exclusive of physician services). The purpose of the Beneficiary Selection form is for you, the beneficiary, to select the method that best suits your requirements. It is important you choose one of these two methods, complete and sign the form and return it to the dialysis facility that supervises your care as soon as possible. You must complete all sections of this form.

This form is to be filled out only by Medicare beneficiaries dialyzing at home and not by Medicare beneficiaries who are currently dialyzing in a facility.

Your selection of either Method I or Method II in no way inhibits your return to incenter treatment or selection for any other treatment options should that be necessary.

METHOD I – The first method is for your dialysis facility to assume the responsibility for your care. Under this method, the facility is required to provide to you any and all dialysis equipment, supplies and home support services that you need to dialyze at home. It also is required to order, store, deliver, and pay the manufacturers and suppliers for these items. Under this arrangement you are responsible to your dialysis facility for the Medicare Part B deductible and 20% coinsurance.

METHOD II – While your facility is responsible for assuring that you receive all items and services that you require for home dialysis, the second method allows you to deal directly with a single supplier for securing the necessary dialysis equipment and supplies. Then your supplier bills the Medicare program for payment. Under this arrangement, you are responsible to the supplier for the Medicare Part B deductible and 20% coinsurance.

METHOD CHANGES – Once you have made your initial selection, your reimbursement must be handled in that manner until December 31 of the year in which you signed the ESRD Beneficiary Selection form. If you wish to continue your initial selection beyond December 31, you do NOT complete another ESRD Beneficiary Selection form. You will automatically continue to have your reimbursement handled in the manner you selected. If you do not wish to continue with your initial selection beyond December 31, you MUST complete another ESRD Beneficiary Selection form. This subsequent form must be signed, dated and postmarked PRIOR to January 1 of the year you wish your selection change to be effective. This is the only way changes are made, and this is the only reason you should ever complete more than one ESRD Beneficiary Selection form.

PRIVACY ACT STATEMENT

As required by 5 U.S.C. 552a (the Privacy Act of 1974), you are advised that the Centers for Medicare & Medicaid Services is authorized to collect the data on this form by Section 1881(b)(1) of the Social Security Act and 42 CFR 405.544. The purpose for collecting this information is stated above. Your response to the questions on this form is not required by law. However, if you do not provide this information, requests for end-stage renal dialysis reimbursement may be denied or delayed until it is provided. You should be aware that the information you provide may be verified by a computer match (P.L. 100-503).

Individually identifiable patient information will not be disclosed except as provided for by the Privacy Act.