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

Form Approved
OMB No. 0938-0046

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

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

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

2. Medicare Beneficiary Identifier or Social Security Number

3. Date of Birth *(mm/dd/yyyy)*

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

5. Phone Number *(including area code)*

6. Sex
☐ Male ☐ Female

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

8. Country/Area of Origin or Ancestry

9. 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 ____________________________

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

11. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ VA ☐ Medicare Advantage ☐ Other ☐ None

12. Height
INCHES ______ OR
CENTIMETERS ______

13. Dry Weight
POUNDS ______ OR
KILOGRAMS ______

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

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

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

16. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions
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
  ☐ 1. Assisted Living
  ☐ 2. Nursing Home
  ☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

17. Prior to ESRD therapy:
a. Did patient receive exogenous erythropoetin 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 dietitian? ☐ 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

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

LABORATORY TEST	VALUE	DATE	LABORATORY TEST		VALUE	DATE
a.1. Serum Albumin (g/dl)	___.___		d. HbA1c		___ ___.___%	
a.2. Serum Albumin Lower Limit	___.___		e. Lipid Profile	TC	___ ___ ___	
a.3. Lab Method Used (BCG or BCP)				LDL	___ ___ ___	
b. Serum Creatinine (mg/dl)	___ ___.___			HDL	___ ___	
c. Hemoglobin (g/dl)	___ ___.___			TG	___ ___ ___ ___	

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

19. Name of Dialysis Facility

20. Medicare Provider Number *(for item 19)*

21. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility

22. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

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

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

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

26. If patient NOT informed of transplant options, please check all that apply:
☐ Patient declined information
☐ Patient has not been assessed
☐ Patient is not eligible medically
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant *(mm/dd/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 *(mm/dd/yyyy)*	31. Name of Preparation Hospital	32. Medicare Provider number for Item 31

33. Current Status of Transplant *(if functioning, skip items 36 and 37)*
☐ Functioning ☐ Non-Functioning

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

35. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*

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

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

37. Name of Training Provider	38. Medicare Provider Number of Training Provider (for Item 37)

39. Date Training Began *(mm/dd/yyyy)*

40. Type of Training
☐ Hemodialysis a. ☐ Home b. ☐ In Center
☐ CAPD ☐ CCPD ☐ Other

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

42. 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.

43. Printed Name and Signature of Physician personally familiar with the patient's training			44. UPIN or NPI of Physician in Item 43
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

45. Attending Physician *(Print)*	46. Physician's Phone No. *(include Area Code)*	47. UPIN or NPI of Physician in Item 45

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.

48. Attending Physician's Signature of Attestation *(Same as Item 45)*	49. Date *(mm/dd/yyyy)*
50. Physician Recertification Signature	51. Date *(mm/dd/yyyy)*

52. 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.

53. Signature of Patient *(Signature by mark must be witnessed.)*	54. 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. 09-700520, "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 RENAL DISEASE

Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-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. **An ICD-10-CM code is effective as of October 1, 2015.**

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

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Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-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. **An ICD-10-CM code is effective as of October 1, 2015.**

ICD-10	DESCRIPTION
HYPERTENSION/LARGE VESSEL DISEASE	
I12.9	Hypertensive chronic kidney disease with stage 1through 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
N05.8	Unspecified nephritic syndrome with other morphologic changes
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

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 14, 16-17, 25-26, 48-49: To be completed by the attending physician.
Item 43: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 53 and 54: 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 Beneficiary Identifier as it appears on his/her Medicare card. If the patient has not yet been assigned a Medicare Beneficiary Identifier, enter the Social Security Number as it appears on his/her Social Security Card. **Only enter the Social Security Number if the patient does not have a Medicare Beneficiary Identifier**.
3. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
4. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
5. Enter the patient's home area code and telephone number.
6. Check the appropriate block to identify sex.
7. 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, Mexican, Puerto Rican, South or Central American, or other Spanish 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.
8. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 9.
9. Check the appropriate block(s) to identify race. The 1997 OMB standards permit the reporting of more than one race. An individual's response to the race question is based upon self-identification.

   Definitions of the racial categories for Federal statistics are as follows:

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

   American Indian/Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

   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—AA person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   Other Race—For respondents unable to identify with any of these five race categories
10. 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.**

DISTRIBUTION OF COPIES:

- **To the Applicant:** Forward the hard copy of this form with original signatures to the Social Security office servicing the claim.
- **To the Dialysis Facility:** Complete the form in Crown Web or maintain a copy with signature's in the patient file.

11. 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.

    VA—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.

12. 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.

13. 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.

14. 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 from page 3 or 4 of form to indicate the primary cause of end stage renal disease. 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. These are the only acceptable causes of end stage renal disease.

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.

    ***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. 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 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 18a thru 18c 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.

18a1. 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.

18a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

18a3. Enter the serum albumin lab method used (BCG or BCP).

18b. 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.

18c. 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.

18d. 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.

18e. 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.

19. Enter the name of the dialysis facility 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 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.

22. 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.

23. 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 52, that patient is restarting dialysis.

24. 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.

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

26. If the patient has not been informed of their options (answered "no" to Item 25), then enter all reasons why a kidney transplant was not an option for this patient at this time.

27. Enter the date(s) of the patient's kidney transplant(s). If reentering 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 non-functioning block.
34. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
35. 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.
36. 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 37-42 if the patient has entered into a self-dialysis training program. Items 37-42 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.

37. Enter the name of the provider furnishing self-care dialysis training.
38. Enter the 6-digit Medicare identification number for the training provider in Item 32.
39. Enter the date self-dialysis training began.
40. 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.
41. 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.
42. Enter date patient completed or is expected to complete self-dialysis training.
43. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
44. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 43. (See Item 47 for explanation of UPIN.)
45. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
46. 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.
47. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 45

    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.

    The NPI is established by the NPI Enumerator located in Fargo, North Dakota. The NPI Enumerator may be contacted by:

    Phone: (800)465-3203 or TTY (800)692-2326.
    Email: customerservice@npienumerator.com.
    Mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

48. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 45. A stamped signature is unacceptable.
49. Enter date physician signed this form.
50. 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.
51. The date physician re-certified and signed the form.
52. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
53. 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**.
54. The date patient signed form.

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 0938-0046 (Expires XX/XX/XXXX). The time required to complete this information collection is 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** 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 the ESRD Network in your region.