ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

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

2. Medicare Number | 3. Social Security Number | 4. Date of Birth *(mm/dd/yyyy)*

5. Sex at Birth
☐ Male ☐ Female

6. Gender Identity
☐Cisgender Man ☐Cisgender Woman
☐Genderqueer/gender nonconforming neither exclusively male nor female
☐Transgender man/trans man
☐Transgender woman/trans woman
☐Additional gender category (or other); please specify: _____

7. Patient State of Residence

8. Date of Death

9. Place of Death
☐ Hospital ☐ Dialysis Facility
☐ Home ☐ Nursing Home
☐ Other ☐ Unknown

10. Modality at the Time of Death
☐ Incenter Hemodialysis ☐ Home Hemodialysis
☐ CAPD ☐ CCPD
☐ Transplant ☐ Other

11. Name of Dialysis Facility/Transplant Center

12. Medicare Provider Number (for item 11)

13. Address of Dialysis Facility/Transplant Center *(Street Address, City, State, Zip Code)*

14. Causes of Death *(enter codes from list on form)*
Primary Cause of Death _____ Secondary Cause of Death _____ _____ _____ _____ ☐ No Secondary
If Cause of Death is Other (98) specify here _____

15. Renal replacement therapy discontinued prior to death:
Yes ☐ No If yes, check one of the following:
☐ Following HD and/or PD access failure
☐ Following transplant failure
☐ Following chronic failure to thrive
☐ Following acute medical complication
☐ Other
Date of last dialysis treatment *(mm/dd /yyyy)*

16. Was discontinuation of renal replacement therapy after ☐ patient/family request to stop dialysis?
☐ Yes ☐ No ☐ Unknown ☐ Not Applicable
☐ Yes, Related to Hospice Care

17. Did the patient ever receive a transplant:
prior to death?
☒ Yes ☐ No ☐ Unknown
If Yes, date of most recent transplant *(mm/dd/yyyy)*

Type of transplant received
☐ Living Related ☐ Living Unrelated ☐ Deceased
☐Unknown
Was transplant graft functioning (patient not on dialysis) at time of death?
☐Yes ☐ No ☐ Unknown
Did transplant patient resume chronic maintenance dialysis prior to death?
☐ Yes ☐ No ☐ Unknown
Did the transplant patient experience a short-term course (acute) of dialysis prior to death?
☐ Yes ☐ No ☐ Unknown

18. Was patient receiving Palliative Care/Hospice care
☐ Yes ☐ No ☐ Both ☐ Neither ☐ Unknown

19. Name of Attending Physician *(Print Complete Name)*

20. Signature of Person Completing Form

21 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

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
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.)
51 Septicemia due to peripheral vascular disease, gangrene
52 Septicemia, other
61 Cardiac infection (endocarditis)
62 Pulmonary infection (pneumonia, influenza)
63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

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

GASTRO-INTESTINAL

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

METABOLIC

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

ENDOCRINE

96 Adrenal insuffciency
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
87 Chronic obstructive lung disease (COPD)
88 Complications of surgery
89 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 Covid-19
100 Severe Adverse Medication Reaction
101 Unknown

INSTRUCTIONS FOR COMPLETING OF ESRD DEATH NOTIFICATION: CMS-2746-U2

1.

2. 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.
3. If the patient is covered by Medicare, enter his/her/their Medicare Beneficiary Identifier (Medicare Number) as it appears on his/her/their Medicare card.
4. Enter the Social Security Number as it appears on his/her/their Social Security Card.
5. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
6. Check the appropriate block to identify sex at birth.
7. Check the appropriate block to indicate the gender the patient identifies as.
8. Enter the two-letter United States Postal Service abbreviation for State in the space provided for the patient's state of residence; e.g., MD for Maryland, NY for New York.
9. Enter patient's date of death (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
10. Check the one block which indicates the location of the patient at time of death. In-transit deaths or dead on arrival (DOA) cases are to be identified by checking "Other."
11. Check the one block, which indicates the patient's modality at time of death. "Other" has been placed on the 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 the Office of Management and Budget.
12. Enter the name of the dialysis facility or transplant center where this patient last received care and who is completing this form.
13. Enter the 6-digit Medicare identification code of the dialysis facility in item 11.
14. Enter the street address of the provider submitting the form with the City, State and Zip Code in which the provider is located.
15. Primary Cause: Enter the numeric code from the list on the form, which represents the patient's primary cause of death. Do not report the same cause of death for primary and secondary causes.

    Identify up to four secondary causes, if available. Enter the code from the list on the form, which represents the secondary cause(s) of death. If there was not secondary cause(s) of death check no secondary.

    If cause of death is "Other" (101) please specify the cause.

    Notes:

    Code 82, "Malignant disease, patient ever on immunosuppressive therapy" is for use when the diagnosis of malignant disease occurred after the start of immunosuppressive therapy

    Code 104, "Withdrew from dialysis" may not be reported as a primary cause of death. A primary cause of death must be selected from the list on the form which would include "Other (101)" with additional information entered.
16. Select yes or no to indicate whether or not the patient voluntarily discontinued renal replacement therapy prior to death.

    If YES, select the option that best describes the condition under which the patient discontinued renal replacement therapy.

    Following HD and/or PD access failure

    Following transplant failure

    Following chronic failure to thrive

    Following acute medical complication

    Other (select if it was a condition of hospice)

    Enter date of last dialysis treatment.
17. Select the choice that best applies. See item 18 for definition of hospice.
18. Select yes if the patient ever received a kidney transplant and complete the remaining question. If the answer is no continue to question 18.

    Enter the date of the most recent transplant in month, day, and year order using an 8-digit number. If unknown, check box for unknown.

    Select the type of transplant received.

    Indicate if the transplant graft was functioning at time of the patient's death.

    Indicate if the kidney transplant failed and the transplant patient resume chronic maintenance dialysis prior to death.

    Indicate if the patient had a short-term course of dialysis to support the kidney

transplant prior to death.

19. Hospice is a program of care and support for people who are terminally ill (with a life expectancy of 6 months or less, if the illness. Palliative care relieves suffering for patients with a chronic illness. Patients may receive one or the other, both, or neither.

20. Print the name of the attending physician.

21. Signature of the person completing the form.

22. Date the form was signed.

Complete the ESRD Death Notification, CMS-2746, within 2 weeks of the date of death. If the patient was a dialysis patient, the dialysis facility last responsible for the patient's maintenance dialysis (or home dialysis) must complete this form. If the patient was a transplant patient, the transplant center is responsible for completing this form.

If you are unable to complete this form in the approved CMS electronic system, forward a hard copy to the ESRD Network in your region.

The form CMS-2746 can be downloaded from CMS.gov or obtained from the ESRD Network in your region.

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). Collection of your Social Security number is authorized by Executive Order 9397. Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a).

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