DEPARTMENT OF HEALTH AND HUMAN SERVICES
FORM APPROVED
CENTERS FOR MEDICARE AND MEDICAID SERVICES

OMB No. 0938-0448

ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

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

2. ~~Patient's Sex a. Male b. Female ☐ Male ☐ Female~~ Medicare Number 3. ~~Date of Birth Month __ Day __ Year ___~~ Social Security Number 4. ~~Medicare Beneficiary Identifier or Social Security Number~~ Date of Birth *(mm/dd/yyyy)*

5. ~~Patient State of Residence~~ Sex at Birth
☐ Male ☐ Female

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

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. ~~Date of Death~~ Patient State of Residence

8. ~~Modality at Time of Death a. Incenter Hemodialysis b. Home Hemodialysis c. CAPD d. CCPD e. Transplant f. Other~~ Date of Death

9. ~~Provider Name and Address (Street)~~ Place of Death
☐ Hospital ☐ Dialysis Facility
☐ Home ☐ Nursing Home
☐ Other ☐ Unknown

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

~~Provider Address (City/State)~~

11. ~~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~~ Name of Dialysis Facility/Transplant Center-

____

12. ~~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 ___ ___ / ___ ___ / ___ ___ ___ ___~~ Medicare Provider Number (for item 11)

13. ~~Was discontinuation of renal replacement therapy after patient/ family request to stop dialysis? Yes No Unknown Not Applicable~~
Address of Dialysis Facility/Transplant Center *(Street Address, City, State, Zip Code)*

14. ~~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~~ 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. ~~Was patient receiving Hospice care prior to death? Yes No Unknown~~ 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. Name of Physician (Please print complete name)~~
Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?
☐ Yes ☐ No ☐ Unknown ☐ Not Applicable
☐ Yes, Related to Hospice Care

17. ~~Signature of Person Completing this Form Date~~

Form CMS-2746-U2 (7/2022)

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

~~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).~~ 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. 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 (Expires XX/XX/XXXX). This is a mandatory to obtain a benefit ESRD Medicare information collection. The time required to complete this information collection is estimated to average 1 hour 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 Lisa Rees.

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 ~~Unknown~~ Covid-19
100 Severe Adverse Medication Reaction
101 Unknown

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

1.

2. ~~Patient's Last Name, First, and Middle Initial Enter the patient's last name, first name, and middle initial as it appears on the Medicare Card or other official SSA notification.~~ 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. ~~Patient's Sex Check the box that indicates the patient's sex.~~ 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. ~~Date of Birth Enter the date in month, day, and year order, using an 8-digit number; e.g., 07/24/2000 for July 24, 2000.~~Enter the Social Security Number as it appears on his/her/their Social Security Card.
5. ~~Medicare Beneficiary Identifier or Social Security Number Enter the patient's Medicare Beneficiary Identifier as it appears on his/her Medicare Card. If the patient has not been assigned a Medicare Beneficiary Identifier, enter the Social Security Number as it appears his/her Social Security Card. Only enter the Social Security Number if the patient does not have a Medicare Beneficiary Identifier.~~ Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
6. ~~Patient's State of Residence Enter the two-letter United States Postal Service abbreviation for State in the space provided; e.g., MD for Maryland, NY for New York.~~ Check the appropriate block to identify sex at birth.
7. ~~Place of Death 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."~~ Check the appropriate block to indicate the gender the patient identifies as.
8. ~~Date of Death Enter the date in month, day, and year order, using an 8-digit number.~~ 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. ~~Modality at Time of Death 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.~~ Enter patient's date of death (2-digit Month, Day, and 4-digit

Year). Example 07/25/1950.

10. ~~Provider Name and Address (City and State) Enter the complete name of the provider submitting the form and the city and State in which the provider is located.~~ 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. ~~Provider Number Enter the provider number (6-digit Medicare identification code) assigned by the Centers for Medicare & Medicaid Services.~~ 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. ~~Causes of Death a. 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. b. Were there secondary causes? Check the one block, which indicates whether or not there were secondary cause(s) of death. If yes, enter the code from the list on the form, which represents the secondary cause(s) of death. c. If cause is "Other" (98) please specify. NOTES: 1. Code 82, "Malignant disease, patient ever on immunosuppressive therapy" means immunosuppressive therapy prior to the diagnosis of malignant disease. 2. Code 104, "Withdrew from dialysis" may not be reported as a cause of death (e.g., Code 98; "Other") and specify.~~ Enter the name of the dialysis facility or transplant center where this patient last received care and who is completing this form.

~~13. Renal Replacement Therapy Discontinued Prior to Death Indicate Yes / No Check the one block, which indicates whether or not the patient voluntarily discontinued renal replacement therapy prior to death. If YES, check one of the following: Check the one box, which best describes the condition under which the patient discontinued renal replacement therapy. 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. Enter date of last dialysis treatment using an 8-digit number~~ Enter the 6-digit Medicare identification code of the dialysis facility in item 11.

14. ~~Was Discontinuation of Renal Replacement Therapy after Patient/Family Request to Stop Dialysis Check the appropriate box that applies. Yes/No / Unknown / or Not Applicable~~ Enter the street address of the provider submitting the form with the City, State and Zip Code in which the provider is located.

15. ~~If Deceased Ever Received a Transplant If the patient had ever received a transplant, complete items a through d. a. Date of most recent transplant. 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. b. Type of transplant received. Check the block that indicates type of transplant received. c. Was graft functioning at time of death? Check appropriate block Yes / No or Unknown. d. Did transplant patient resume chronic maintenance dialysis prior to death? Check appropriate block Yes / No or Unknown.~~
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. ~~Was Patient Receiving Hospice Care Prior to Death? Check appropriate block Yes / No / or Unknown.~~ 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. ~~Name of Physician Enter the name of the physician supplying the information for this form.~~ Select the choice that best applies. See item 18 for definition of hospice.

18. ~~Signature of Person Completing this Form The person completing the form should sign this space. The date should be entered.~~ 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.

~~Distribution of Copies~~

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.

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