

[DATE]

[FIRST NAME] [LAST NAME]

[ADDRESS]

[CITY, STATE AND ZIP]

PLEASE TELL US ABOUT YOUR DIALYSIS CARE

Dear [FIRST NAME] [LAST NAME]:

This is an important survey from Medicare for people who get dialysis. We hope you will take the time to share your experiences about [FACILITY NAME]. **Your feedback helps Medicare improve the overall quality of dialysis care that you and others like you receive, and also helps others choose a dialysis center that is right for them.**

You can learn more about the survey and see ratings of dialysis centers and staff online at www.medicare.gov/care-compare under the provider type “Dialysis facilities.” For common questions and answers about the survey, you can also visit <https://ichcahps.org> and click on the “DIALYSIS PATIENTS Click Here” button.


Your voice matters. You *may* be asked to complete the survey up to two times a year so that Medicare can understand how dialysis patients’ experiences change over time. Participation is voluntary, and your information is kept private by law. No one can connect your name to your answers.

Please do not ask anyone from [FACILITY NAME] for help with this survey. We are interested in your own opinions about your dialysis care. Please return the survey in the enclosed pre-paid envelope.

For additional questions about the survey, please call [VENDOR NAME], toll-free at [VENDOR 800 NUMBER], [DAYS], between [HOURS AND TIME ZONE]. *(Si usted tiene preguntas acerca de esta encuesta o desea recibirla en español, por favor llame al administrador de encuestas al [VENDOR 800 NUMBER].)*

Thank you for helping to improve dialysis care.

Sincerely,



Vanessa S. Duran

Director

Medicare Drug Benefit and C & D Data Group

collection is estimated to average less than 16 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory for qualifying dialysis facilities under 42 CFR §413.178(c)(iii) to meet program requirements and voluntary for survey respondents. Confidentiality is assured under 5 U.S.C. 552a (Privacy Act of 1974). 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 C1-25-05, Baltimore, Maryland 21244-1850.