Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C1-25-05
Baltimore, Maryland 21244-1850

[DATE]
[FIRST NAME] [LAST NAME]
[ADDRESS]
[CITY, STATE AND ZIP]

PLEASE TELL US ABOUT YOUR DIALYSIS CARE

Dear [FIRST NAME] [LAST NAME]:

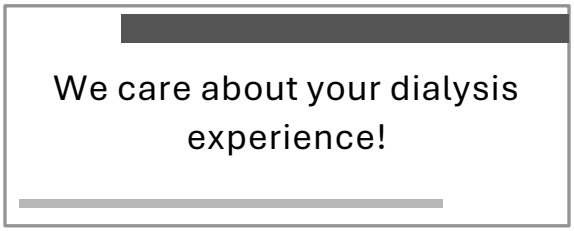
You recently received a survey from Medicare about your experiences with [FACILITY NAME]. If you already sent this survey back, thank you! You do not need to do anything else.

If you have not sent the survey back, **this is a friendly reminder that we are very interested in learning about your experiences.** Your responses will help others choose a dialysis center that is right for them and will help Medicare improve the overall quality of dialysis care you and others like you receive. Please return the survey in the enclosed pre-paid envelope.

Your voice matters. We know your time is valuable. Participation is voluntary, and your information is kept private by law. No one can connect your name to your answers. You can learn more about the survey and see ratings of in-center hemodialysis centers and staff online at www.medicare.gov/care-compare under the provider type "Dialysis facilities."

If you have questions about this survey, please call RTI International, the organization working with Medicare, (toll-free) at 1-866-245-8083 or send an email to ichcahpsmode@rti.org.

Thank you for helping to improve dialysis care.



Sincerely,

Center for Medicare

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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 0938-0926. This information collection produces comparable data from dialysis facilities to help individuals choose a facility and improve care. The time required to complete this information collection is estimated to average less than 11 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. ******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 ICHCAHPS@cms.hhs.gov.**