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

Form Approved
OMB No. 0938-0046
Expires: 11/30/2026

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT

Medicare Entitlement and/or Patient Registration

A. Complete for all ESRD patients.

Select one: ◯ **Initial** ◯ **Re-entitlement** ◯ **Supplemental**

1. Last name	First name	Middle initial

2. Medicare Number (if available)	3. Social Security Number (SSN)	4. Date of birth (mm/dd/yyyy)

5. Patient mailing address (include city, state and ZIP code)

6. Phone number (including area code)	7. Alternate phone number (including area code)

8. What is your sex?

◯ Male ◯ Female

9. Is patient applying for ESRD Medicare coverage? ..... ◯ Yes ◯ No

10. Current medical coverage (check all that apply)

☐ Employer group health insurance
☐ Medicare
☐ Medicaid
☐ Veterans Administration
☐ Medicare Advantage
☐ Other
☐ None

11. Height: inches _____ **OR** centimeters _____	12. Dry weight: pounds _____ **OR** kilograms _____

13. Primary cause of renal failure (use code at end of form)

14. Occupation status (6 months prior and current status)

Prior	Current		Prior	Current	
◯	◯	Unemployed	◯	◯	Retired (disability)
◯	◯	Employed full time	◯	◯	Medical leave of absence
◯	◯	Employed part time	◯	◯	Student
◯	◯	Homemaker	◯	◯	Volunteer
◯	◯	Retired due to age/preference			

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.

15. Co-morbid conditions (check all that apply currently and/or during last 10 years)

- ☐ 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
  - ☐ Currently use other injectable
  - ☐ On oral medications
  - ☐ Without medications
- ☐ i. Diabetic retinopathy
- ☐ j. Chronic obstructive pulmonary disease
- ☐ k. Tobacco use (current smoker)
- ☐ l. Malignant neoplasm, cancer
- ☐ m. Toxic nephropathy
- ☐ n. Alcohol dependence
- ☐ o. Drug dependence*
- ☐ p. Inability to ambulate*
- ☐ q. Inability to transfer*
- ☐ r. Needs assistance with daily activities*
- ☐ s. Alternate housing arrangement:
  - ☐ Assisted living
  - ☐ Nursing home
  - ☐ Other institution
- ☐ t. Non-renal congenital abnormality
- ☐ u. None (no comorbidities)
- ☐ v. Protein calorie malnutrition
- ☐ w. Morbid obesity
- ☐ x. Endocrine metabolic disorders
- ☐ y. Intestinal obstruction/perforation
- ☐ z. Chronic pancreatitis
- ☐ aa. Inflammatory bowel disease
- ☐ bb. Bone/joint/muscle infections/ necrosis
- ☐ cc. Dementia
- ☐ dd. Major depressive disorder
- ☐ ee. Myasthenia gravis
- ☐ ff. Guillain-Barre syndrome
- ☐ gg. Inflammatory neuropathy
- ☐ hh. Parkinson's disease
- ☐ ii. Huntington's disease
- ☐ jj. Seizure disorders and convulsions
- ☐ kk. Interstitial lung disease
- ☐ ll. Partial-thickness dermis wounds
- ☐ mm. Complications of specified implanted device or graft
- ☐ nn. Artificial openings for feeding or elimination

Consider for Pediatric Patients:

- ☐ oo. Chronic lung disease (including dependency on CPAP and ventilators)
- ☐ pp. Vision impairment
- ☐ qq. Feeding tube dependence
- ☐ rr. Failure to thrive/feeding disorders
- ☐ ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
- ☐ tt. Congenital bladder/urinary tract anomalies
- ☐ uu. Non-kidney solid organ
- ☐ vv. Stem cell transplant
- ☐ ww. Neurocognitive impairment
- ☐ xx. Global developmental delay
- ☐ yy. Cerebral palsy
- ☐ zz. Seizure disorder

16. 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 routine care of a nephrologist? ..... ◯ Yes ◯ No ◯ Unknown
If yes, answer: ◯ <6 months ◯ 6-12 months ◯ >12 months

c. Was patient under routine 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 ◯ PD catheter ◯ Central venous catheter ◯ Other

If not AVF, then: Is maturing AVF present? ..... ◯ Yes ◯ No
Is graft present? ..... ◯ Yes ◯ No
Was one lumen of the central venous catheter used and one needle placed in a AVF or graft? ..... ◯ Yes ◯ No
Is PD catheter present? ..... ◯ Yes ◯ No

e. Was patient diagnosed with an acute kidney injury in the last 12 months? ..... ◯ Yes ◯ No ◯ Unknown
If yes, was dialysis required? ..... ◯ Yes ◯ No

f. Does the patient indicate they received and understood options for a home dialysis modality? ..... ◯ Yes ◯ No

g. Does the patient indicate they received and understood options for a kidney transplant? ..... ◯ Yes ◯ No
For living donor transplant ..... ◯ Yes ◯ No

h. Does the patient indicate they received and understood the option of not starting dialysis at all, also called active medical management without dialysis? ..... ◯ Yes ◯ No

*Go to instructions

17. Laboratory values within 45 days prior to the most recent ESRD episode. If not available within 30 days of admission to the dialysis facility for ESRD treatment, admission laboratory values may be used. (HbA1c and LDL within 1 year of most recent ESRD episode). (select one)

◯ Prior lab values ◯ Admission lab values

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Serum albumin g/dl	___.___		e. Hemoglobin g/dl	___.___	
b. Serum albumin lower limit	___.___		f. HbA1c	___.___	
c. Lab method used (BCG/BCP)	___.___		g. LDL	___.___	
d. Serum creatinine mg/dl	___.___		h. Cystatin C	___.___	

18. Does the patient have living will or medical/physician order for life sustaining treatment? ..... ◯ Yes ◯ No

19. Are you currently concerned about where you will live over the next 90 days? ..... ◯ Yes ◯ No

20. Do you have caregiver support to assist with your daily care? ..... ◯ Yes ◯ No
With home dialysis/kidney transplant? ..... ◯ Yes ◯ No
Does the caregiver live with you? ..... ◯ Yes ◯ No

21. Do you have access to reliable transportation? ..... ◯ Yes ◯ No

22. Do you understand the information received to make an informed healthcare decision? ..... ◯ Yes ◯ No

23. Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating? ..... ◯ Yes ◯ No

24. Within the past 12 months, has the food you bought not lasted and you didn't have money to get more? ... ◯ Yes ◯ No

25. Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months? ..... ◯ Yes ◯ No

B. Complete for all ESRD patients in dialysis treatment

26. Name of dialysis facility

27. CMS Certification Number (CCN) (for item 26)

28. Primary dialysis setting (select one)
◯ Home ◯ In-center ◯ SNF/LTC*

29. Primary type of dialysis (select one)
◯ Hemodialysis (sessions per week____/minutes per session____) ◯ CAPD ◯ CCPD ◯ Other

30. Date regular chronic dialysis began (mm/dd/yyyy)

31. Date patient started chronic dialysis at current facility (mm/dd/yyyy)*

32. Does the patient understand kidney transplant options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 16(g)

33. If patient NOT informed of transplant options (or does not understand transplant options) please check all that apply:

☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

34. Has the patient been connected to a transplant center with a referral?* ..... ◯ Yes ◯ No
Date of referral (mm/dd/yyyy): _____
Name of transplant center: _____

35. Does the patient understand home dialysis options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 16(f)

36. If patient NOT informed of home dialysis options (or does not understand home dialysis options) please check all that apply:

☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

*Go to instructions

C. Complete for all kidney transplant patients

37. Date of transplant (mm/dd/yyyy)

38. Name of transplant hospital	39. CMS Certification Number (CCN) (for item 38)

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.

40. Enter date (mm/dd/yyyy)

41. Name of preparation hospital	42. CMS Certification Number (CCN) (for item 41)

43. Current status of transplant (if functioning, skip items 45 and 46)

◯ Functioning ◯ Non-functioning

44. Type of transplant (select one)

◯ Deceased donor ◯ Living related ◯ Living unrelated ◯ Multi-organ ◯ Paired exchange

45. If non-functioning, date of return to regular dialysis (mm/dd/yyyy)

46.Current dialysis setting (select one)

◯ Home ◯ In-center ◯ SNF/LTC* ◯ Transitional care unit*

D. Complete for all ESRD self-dialysis training patients (Medicare applicants only)

47. Name of training provider

48. CMS Certification Number (CCN) of training provider (for item 47)	49. Date training began (mm/dd/yyyy)

50. Type of training

☐ Hemodialysis (select one): a. ◯ Home b. ◯ In-center
☐ CAPD
☐ CCPD
☐ Other

51. This patient is expected to complete (or has completed) training and will self-dialyze on a regular basis. ..... ◯ Yes ◯ No

52. 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.

53. Printed name and signature of physician personally familiar with the patient's training

a. Printed name

b. Signature	c. Date (mm/dd/yyyy)

54. NPI of physician (for item 53)

*Go to instructions

E. Physician Identification

55. Attending physician (print)

56. Physician's phone number (include area code)	57. NPI of physician

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.

58. Attending physician's signature of attestation (same as item 55)	59. Date (mm/dd/yyyy)
60. Physician recertification signature	61. Date (mm/dd/yyyy)

62. 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.

63. Signature of patient (signature by mark must be witnessed.)	64. Date (mm/dd/yyyy)

If patient unable to sign/mark: (select one)

◯ Lost to follow-up ◯ Moved out of the United States and territories ◯ Expired date (mm/dd/yyyy)

G. Privacy statement

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LIST OF PRIMARY CAUSES OF RENAL DISEASE

Item 17. 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 February 1, 2022.

Diabetes

E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
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

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

Hypertension/large vessel disease

I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal 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 malformation 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
D41.9	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

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

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
U07.1	COVID19

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

Submission of CMS-2728 form:

- **To the applicant:** Forward a hard, fax, or email copy of this form with signatures to the Social Security office in your area.
- **To the dialysis facility:** Complete this form in the ESRD Quality Reporting System (EQRS) and print. Provide the applicant with a copy of the form and/or assist them in submitting the form to the appropriate Social Security office.

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: Fill in the appropriate circle 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 13, 15–16, 32–36, 58–59:** To be completed by the attending physician.
- **Item 53:** To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training
- **Items 63 and 64:** 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/their Medicare Beneficiary Identifier (Medicare Number) as it appears on his/her/their Medicare card.
3. Enter the Social Security Number as it appears on his/her/their Social Security card. If the patient voices concern explain this is necessary to correctly match the patient so benefits can be assigned.
4. Enter patient's date of birth (2-digit month, day, and 4-digit year). Example 07/25/1950.
5. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP Code.)
6. Enter the patient's area code and telephone number.
7. Enter the patient's alternate area code and telephone number, if available for disaster purposes.
8. Ask the patient and select the appropriate option to identify their sex.

9. Select yes or no 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. Additionally, if the patient has private insurance beginning dialysis starts the 30-month coordination of benefits period. If the patient doesn't accept Medicare Part B during the 30-month window, they may lose the ability to apply until the General Enrollment Period (GEP) and will likely face gaps in coverage and a late enrollment penalty.**

10. Check all the blocks that apply to this patient's current medical insurance status.
    - **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.
    - **Medicare:** Patient is currently entitled to Federal Medicare benefits.
    - **Medicaid:** Patient is currently receiving State Medicaid benefits.
    - **Veterans Administration:** Patient is receiving medical care from a Department of Veterans Affairs facility.
    - **Medicare Advantage:** Patient is receiving medical benefits under a Medicare Advantage (Medicare Part A and Part B coverage offered by Medicare-approved private companies that must follow rules set by Medicare) organization.
    - **Other medical insurance:** Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, Medicare Advantage, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries or that obtains insurance through the Marketplace.
    - **None:** Patient has no medical insurance plan.

11. 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.**

12. 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 without prosthesis.**

13. 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 4 or 6 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 February 1, 2022. These are the only acceptable causes of end stage renal disease.

14. Select the first option to indicate occupation 6 months prior to renal failure and the second option to indicate current occupation. **Select only one option for each time period.** If patient is under 6 years of age, leave blank.

15. This section was broadened to be more inclusive of pediatric patients. **I and J were intentionally not used in the lettering to accommodate previous system comorbidities and provide lettering continuity.**

    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 i**ncludes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.
    - **Drug dependence** means dependent on illicit drugs.
    - **Inability to ambulate** includes an impairment(s) that interferes very seriously with the individual's ability to independently initiate or sustain ambulation
    - **Inability to transfer** from bed to chair, or chair to chair, or chair to bed
    - **Needs assistance with daily activities** including basic physical needs, comprised the following areas: grooming/personal hygiene, dressing, toileting/continence, and eating

    The section titled "Consider for Pediatric Patients" should only be used for pediatric patients.

16. Prior to ESRD therapy, select the appropriate option to indicate whether the patient:
    a. received Exogenous erythropoietin (EPO) or equivalent,
    b. was under the routine care of a nephrologist
    c. was under the routine care of a kidney dietitian
    d. provide vascular access information as to the type of access used **for the majority of the treatment** (Arterio-Venous Fistula (AVF), graft, peritoneal dialysis (PD) catheter, or Central Venous 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 AVF or graft present? Was one lumen of the Central Venous Catheter used and one need placed in a AVF or graft?
    e. Indicate if the patient experienced acute renal failure (the sudden inability for the kidney to filter waste products which may resolve or evolve to ESRD) and if dialysis was required.
    f. Indicate the patient received and understood options for a home dialysis modality.
    g. Indicate if the patient received and understood options for a kidney transplant. For living donor transplant.
    h. Indicate if the patient received and understood the option of not starting dialysis at all, also called active medical

NOTE: For those patients re-entering the Medicare program after benefits were terminated, items in question 17 should contain initial laboratory values within 45 days prior to the most recent ESRD episode (item 31). If a dialysis facility is unable to obtain the laboratory values from the appropriate care setting within 30 days, the dialysis facility may use admission laboratory values drawn prior to initiating the first treatment at the facility LDL and HbA1c should be within 1 year of the most recent ESRD episode (item 31). These tests may not be required for patients under 21 years of age (LDL or HbA1c unless the child is a diabetic).

17.
   a. 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. If a dialysis facility is unable to obtain the laboratory values from the appropriate care setting within 30 days, the dialysis facility may use admission laboratory values drawn prior to initiating the first treatment at the facility.
   b. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in serum albumin.
   c. Enter the serum **albumin lab method used (BCG or BCP).**
   d. 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. If a dialysis facility is unable to obtain the laboratory values from the appropriate care setting within 30 days, the dialysis facility may use admission laboratory values drawn prior to initiating the first treatment at the facility.
   e. 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. If a dialysis facility is unable to obtain the laboratory values from the appropriate care setting within 30 days, the dialysis facility may use admission laboratory values drawn prior to initiating the first treatment at the facility.
   f. 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.
   g. Enter the LDL value with date test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.
   h. Cystatin C value (mg/l) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

18. Ask the patient and document if they have executed a living will or a medical/physician order for life sustaining treatment

19. Ask the patient if they have concerns about where they will live over the next 90 days.

20. Ask the patient if they have caregiver support to assist with daily care. Daily care means actives of daily living, bathing, dressing, etc. Ask the patient if they have a caregiver to assist with home dialysis or a kidney transplant. Ask the patient if the caregiver lives with them.

21. Ask the patient if they have access to reliable transportation. Reliable transportation means the patient can travel to all dialysis treatments, medical appointments, grocery store, pharmacy, etc. without issue.

22. Ask the patient if they understand the information received to make an informed healthcare decision.

23. Ask the patient if they find it hard to pay for the very basics like housing, medical care, electricity, and heating.

24. Ask the patient if the food they bought has not lasted and they didn't have money to get more in the last 12 months.

25. Ask the patient if anyone, including family and friends, has threatened them with harm or physically hurt you in the last 12 months.

26. Enter the name of the dialysis facility where this patient is currently receiving care and who is completing this form for the patient.

27. Enter the 6-digit CMS Certification Number (CCN) of the dialysis facility in item 26.

28. 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.
    - **SNF/LTC:** Check this box only if a patient is residing in a Medicare certified skilled nursing facility and/or long-term care facility **and** receiving dialysis **within** the nursing facility. Dialysis may be performed by patient, family, nursing facility staff, or home dialysis staff, but the patient **is not** transported outside the facility to receive dialysis.
      Note: Transitional care unit is not included in item 28 as it is not anticipated that it will become the long-term treatment center. It is included in item 46 because it can be a current setting when a transplant rejection occurs.

29. 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 minutes that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. **Select only one option.**
    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.

30. 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/their ability to remove or adjust blood wastes that in order to maintain life he/she/they 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 62, that patient is restarting dialysis.

31. 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 30.

32. Enter whether the patient has been informed of and understands their options for receiving a kidney transplant. **Dialysis facilities are required to inform patients of their rights to transplant and other renal replacement modality options at 42 CFR § 494.70(a)(7).** To be informed a patient must understand the material. The patient must be able to repeat: benefits and risk of transplant as a treatment option, the referral and evaluation process, and post-transplant recovery and coordination. Additionally, the patient should be able to verbalize why they did not choose transplant as a treatment option.

33. If the patient has not been informed of their options or does not understand their transplant options (answered "no" to item 32), then enter all reasons why a transplant was not an option for this patient at this time. If a patient was overwhelmed by the information or refused information at this time, the patient should be approached again within a six-month period and the option considered at least at every care conference. Cognitive impairment should be checked if the patient has **trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life** patients and others should not be listed as having an absolute medical contraindication if there is a potential for a transplant center to work with the patient.

34. Enter if the patient was connected to a transplant center for referral along with the date. 42 CFR § 494.90 (a)(7)(ii) indicates the interdisciplinary team must make plans for pursuing the transplant. The dialysis facility is responsible for assisting the patient in coordinating with the transplant center.

35. Enter whether the patient has been informed of and understands their options for receiving dialysis in a home setting. **Dialysis facilities are required to inform patients of their rights to transplant and other renal replacement modality options at 42 CFR § 494.70(a)(7).** To be informed a patient must understand the material. The patient must be able to repeat: benefits and risk of home dialysis as a treatment option. Additionally, the patient should be able to verbalize why they did not choose home dialysis as a treatment option.

36. If the patient has not been informed of their options or does not understand their home dialysis options (answered "no" to item 35), then enter all reasons why home dialysis was not an option for this patient at this time. If a patient was overwhelmed by the information or refused information at this time, the patient should be approached again within a six-month period and the option considered at least at every care conference. Cognitive impairment should be checked if the patient has **trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life** patients and others should not be listed as having an absolute medical contraindication if there is a potential for a home dialysis provider to work with the patient.

37. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date

38. Enter the name of the hospital where the patient received a kidney transplant on the date in item 37.

39. Enter the 6-digit CMS Certification Number (CCN) of the hospital in item 38 where the patient received a kidney transplant on the date entered in item 37.

40. 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.

41. 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.

42. Enter the 6-digit CMS Certification Number (CCN) for hospital in item 41.

43. Select the appropriate option to identify functioning or non-functioning.

44. Enter the type of kidney transplant, deceased donor, living related, living unrelated, multi-organ, or paired exchange that the patient received.

45. 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.

46. If applicable, select where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is only an option if a home modality is being received within the nursing facility not if a certified in- center dialysis facility operates on the grounds. **Note:** Transitional Care Unit is not included in item 28 as it is not anticipated that it will become the long-term treatment center. It is included in item 46 because it can be a current setting when a transplant rejection occurs.

    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 47–54 if the patient has entered into a self-dialysis training program. Items 47–54 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.

47. Enter the name of the provider furnishing self-care dialysis training.

48. Enter the 6-digit CMS Certification Number (CCN) for the training provider in item 47.

49. Enter the date self-dialysis training began.

50. 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.**

51. Select the appropriate option 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.

52. Enter date patient completed or is expected to complete self- dialysis training.

53. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.

54. Enter the National Provider Identifier (NPI) of physician in item 53. (Go to item 57 for explanation of NPI.)

55. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.

56. 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.

57. Enter the National Provider Identifier (NPI) of physician in item 55. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The National Provider Identifier (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers and entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS- 0045-F). Effective May 23, 2008, the NPI replaced the UPIN as a unique identifier. This change request updates chapter 14, of Pub.100-08, Medicare Program Integrity Manual, by removing information related to the issuance and maintenance of UPIN and replacing this information with information about obtaining NPI and UPIN data. The NPI registry allows users to perform simple queries to retrieve read-only information from NPPES. For example, users may search by the NPI or legal business name to locate the NPPES records and search for an individuals or organizations. The NPI Registry will return the results of the query to the user, and the user will click on the record(s) he/she wants to view. **NPIregistry.cms.hhs.gov/**

58. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in item 55. A stamped signature is unacceptable unless required by a disability. An electronic signature is permissible. Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods. If the physician chooses to use a wet signature it should be in ink.

59. Enter the date the physician signed this form. This date should be within the 45 days allowed to complete the form. If a patient is transferred prior to the form being signed, the timeframe for a signature is extended to 75 days. The expectation of CMS is that the transferring facility will make every effort to obtain the physician signature and will cooperate with the receiving facility in this effort.

60. **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. To be signed by the physician who is currently following the patient.

61. The date physician re-certified and signed the form.

62. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office. **If re-entering the Medicare program it should be entered here.**

63. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. The signature may be electronic; however, the dialysis facility bears the burden in obtaining documentation that the patient has consented to the use of electronic signature.

    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. If a signature cannot be obtained because the patient is lost to follow- up, moved outside of the United States or its territories, or has expired check the correct box. If the patient has expired provide the date of death.

64. The date patient signed form.