END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS Check one:	Initial □ Re-entitlement □ Supplemental
1. Name (Last, First, Middle Initial)	
Medicare Claim Number 3. Social Secu	rity Number 4. Date of Birth
	MM DD YYYY
5. Patient Mailing Address (Include City, State and Zip)	6. Phone Number
7. Sex 8. Ethnicity	Country/Area of Origin or Ancestry
	c or Latino (Complete Item 9)
10. Race (Check all that apply) ☐ White ☐ Asian	11. Is patient applying for ESRD Medicare coverage? Under Pacific Islander* The patient applying for ESRD Medicare coverage? No
Print Name of Enrolled/Principal Tribe *complete Item 9	
12. Current Medical Coverage (Check all that apply) 13 ☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance ☐ DVA ☐ Medicare Advantage ☐ Other ☐ None	B. Height 14. Dry Weight 15. Primary Cause of Renal Failure (Use code from back of form) CENTIMETERS OR KILOGRAMS
current status) a. □ Congestive hear b. □ Atherosclerotic h c. □ Other cardiac dis	neart disease ASHD sease Double dependence Drug dependence* Inability to ambulate sension Institutionalized Indications Interpretation In
b. Was patient under care of a nephrologist?	□ No □ Unknown If Yes, answer: □ 6-12 months □ >12 months □ No □ Unknown If Yes, answer: □ 6-12 months □ >12 months □ Graft □ Catheter □ Other □ No □ No
19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Epis	
LABORATORY TEST VALUE DATE	LABORATORY TEST VALUE DATE
a.1. Serum Albumin (g/dl)	d. HbA1c%
a.2. Serum Albumin Lower Limit	e. Lipid Profile TC
a.3. Lab Method Used (BCG or BCP)	LDL
b. Serum Creatinine (mg/dl)	HDL
c. Hemoglobin (g/dl)	TG
B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREA	
20. Name of Dialysis Facility	21. Medicare Provider Number (for item 20)
22. Primary Dialysis Setting ☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility	Primary Type of Dialysis Hemodialysis (Sessions per week/hours per session) CAPD □ CCPD □ Other
24. Date Regular Chronic Dialysis Began	25. Date Patient Started Chronic Dialysis at Current Facility MM DD YYYY
26. Has patient been informed of kidney transplant options? ☐ Yes ☐ No	27. If patient NOT informed of transplant options, please check all that apply: ☐ Medically unfit ☐ Patient declines information ☐ Unsuitable due to age ☐ Patient has not been assessed ☐ Psychologically unfit ☐ Other

C. COMPLETE FOR ALL KIDNE	Y TRANSPLANT PATIENTS		
28. Date of Transplant	29. Name of Transplant Hospital		30. Medicare Provider Number for Item 29
MM DD YYYY			
Date patient was admitted as an ir actual transplantation.	npatient to a hospital in prepara	tion for, or anticipation of, a	kidney transplant prior to the date of
31. Enter Date	32. Name of Preparation Hospita	I	33. Medicare Provider number for Item 32
34. Current Status of Transplant (if fun ☐ Functioning	nctioning, skip items 36 and 37) Non-Functioning	35. Type of Donor: ☐ Deceased ☐ Liv	ing Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return MM DD YYYY	to Regular Dialysis	37. Current Dialysis Treatme	ent Site Facility/Center
D. COMPLETE FOR ALL ESRD	SELF-DIALYSIS TRAINING PA	ATIENTS (MEDICARE APP	LICANTS ONLY)
38. Name of Training Provider		39. Medicare Provider Numb	per of Training Provider (for Item 38)
40. Date Training Began		41. Type of Training	Hemodialysis a. ☐ Home b. ☐ In Center
MM DD YYYY			CAPD □ CCPD □ Other
 This Patient is Expected to Comple and will Self-dialyze on a Regular 		43. Date When Patient Com	pleted, or is Expected to Complete, Training
☐ Yes ☐ No			MM DD YYYY
I certify that the above self-dialys psychological, and sociological			sideration of all pertinent medical, ility.
44. Printed Name and Signature of Ph	ysician personally familiar with the	patient's training	45. UPIN of Physician in Item 44
a.) Printed Name	b.) Signature	c.) Date MM DD YYYY	
E. PHYSICIAN IDENTIFICATION		c.) Date WIW DD 1111	
		17 DI DI N	40 UDIN 6DL :: : ! !! 40
46. Attending Physician (Print)		47. Physician's Phone No.	48. UPIN of Physician in Item 46
	PHYSICIAN	ATTESTATION	
tests and laboratory findings, I further permanent and requires a regular co	er certify that this patient has rea urse of dialysis or kidney transp tlement to Medicare benefits and	ached the stage of renal impa lant to maintain life. I unders I that any falsification, misre	tand that this information is intended for presentation, or concealment of essential
49. Attending Physician's Signature of	Attestation (Same as Item 46)		50. Date
			MM DD YYYY
51. Physician Recertification Signature	;		52. Date
			MM DD YYYY
53. Remarks			
F. OBTAIN SIGNATURE FROM I	PATIENT		
I hereby authorize any physician information about my medical coapplication for Medicare entitlem	ondition to the Department of	Health and Human Servi	ces for purposes of reviewing my
54. Signature of Patient (Signature by	mark must be witnessed.)		55. Date
			MM DD YYYY

G. PRIVACY STATEMENT

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. 09-70-0520, "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. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE

Item 15. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-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. **Code effective as of September 2003**.

DIABE	TES	CYSTIC/HEREDITARY/CONGENITAL DISEASES												
25040	Diabetes with renal manifestations Type 2	75313	Polycystic kidneys, adult type (dominant)											
25041	Diabetes with renal manifestations Type 1	75314	Polycystic, infantile (recessive)											
		75316	Medullary cystic disease, including nephronophthisis											
GLOMI	ERULONEPHRITIS	7595	Tuberous sclerosis											
5829	Glomerulonephritis (GN)	7598	Hereditary nephritis, Alport's syndrome											
	(histologically not examined)	2700	Cystinosis											
5821	Focal glomerulosclerosis, focal sclerosing GN	2718	Primary oxalosis											
5831	Membranous nephropathy	2727	Fabry's disease											
58321	Membranoproliferative GN type 1, diffuse MPGN	7533	Congenital nephrotic syndrome											
58322	Dense deposit disease, MPGN type 2	5839	Drash syndrome, mesangial sclerosis											
58381	IgA nephropathy, Berger's disease	75321	Congenital obstruction of ureterpelvic junction											
00001	(proven by immunofluorescence)	75322	Congenital obstruction of uretrovesical junction											
58382	IgM nephropathy (proven by immunofluorescence)	75329	Other Congenital obstructive uropathy											
5834	With lesion of rapidly progressive GN	7530	Renal hypoplasia, dysplasia, oligonephronia											
5800	Post infectious GN, SBE	75671	Prune belly syndrome											
5820	Other proliferative GN	75989	Other (congenital malformation syndromes)											
SECON	IDARY GN/VASCULITIS	NEOPL	NEOPLASMS/TUMORS											
		1890	Renal tumor (malignant)											
7100	Lupus erythematosus, (SLE nephritis)	1899	Urinary tract tumor (malignant)											
2870	Henoch-Schonlein syndrome	2230	Renal tumor (benign)											
7101	Scleroderma	2239	Urinary tract tumor (benign)											
28311	Hemolytic uremic syndrome	23951	Renal tumor (unspecified)											
4460	Polyarteritis	23952	Urinary tract tumor (unspecified)											
4464	Wegener's granulomatosis	20280	Lymphoma of kidneys											
58392	Nephropathy due to heroin abuse and related drugs	20300	Multiple myeloma											
44620	Other Vasculitis and its derivatives	20308	Other immuno proliferative neoplasms											
44621	Goodpasture's syndrome		(including light chain nephropathy)											
58391	Secondary GN, other	2773	Amyloidosis											
		99680	Complications of transplanted organ unspecified											
INTERS	STITIAL NEPHRITIS/PYELONEPHRITIS	99681	Complications of transplanted kidney											
9659	Analgesic abuse	99682	Complications of transplanted liver											
5830	Radiation nephritis	99683	Complications of transplanted heart											
9849	Lead nephropathy	99684	Complications of transplanted lung											
5909	Nephropathy caused by other agents	99685	Complications of transplanted bone marrow											
27410	Gouty nephropathy	99686	Complications of transplanted pancreas											
5920	Nephrolithiasis	99687	Complications of transplanted intestine											
5996	Acquired obstructive uropathy	99689	Complications of other specified transplanted organ											
5900	Chronic pyelonephritis, reflux nephropathy	MICCE	LI ANEQUE CONDITIONS											
58389	Chronic interstitial nephritis	MISCE	LLANEOUS CONDITIONS											
58089	Acute interstitial nephritis	28260	Sickle cell disease/anemia											
5929	Urolithiasis	28269	Sickle cell trait and other sickle cell (HbS/Hb other)											
27549	Other disorders of calcium metabolism	64620	Post partum renal failure											
		042	AIDS nephropathy											
HYPER	RTENSION/LARGE VESSEL DISEASE	8660	Traumatic or surgical loss of kidney(s)											
		5724	Hepatorenal syndrome											
40391	Unspecified with renal failure	5836	Tubular necrosis (no recovery)											
4401	Renal artery stenosis	59389	Other renal disorders											
59381 50383	Renal artery occlusion Chalesteral embali renal embali	7999	Etiology uncertain											

Cholesterol emboli, renal emboli

59383

ESRD DEATH NOTIFICATION END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1.	Patient's Last Name	First		MI	2.	Medicare Claim Nu	umber
3	Patient's Sev	1	Date of Rirth			5 Social Security	Number
٥.		-	I I			o. Oocial occurry	Number
	a. □ Male b. □ Female		Month Day -	Vear —			
-6	Patient's State of Residence	7	·	Teal		8 Date of Death	
٥.	r attent o ctate of recoldence			е 🗆 О		1	
						1	Day Year —
9.	Modality at Time of Death						
	•	□ Hom	ne Hemodialysis c. \square C	CAPD d.		CCPD e. □ Trai	nsplant f. □ Other
10.	Provider Name and Address (Street)				11. Pro	ovider Number
	Provider Address (City/State)						
12	Causes of Death (enter codes from	liet on	back of form)				
14.		iiot OH	Daok of formi				
	b. Were there secondary causes?						
	No						
	Yes, specify:						
	C. If cause is other (98) please spe	cify:					
	, ,,	,					
12	Devel replacement thereby disconti		wien to death. Vos [7 No. 14	4 \	Men dinantinuation	of would would come out
3. Patient's Sex a.							
	If yes, check one of the following		C	dialysis?			
	a. \square Following HD and/or PD acc	ess fa	ilure				
	b. ☐ Following transplant failure			[Yes	No	
	c. ☐ Following chronic failure to the	nrive					
	d. Following acute medical com	plicati	on			Unknown	Not Applicable
	•						
12. Causes of Death (enter codes from list on a. Primary Cause			1 1				
	i. Date of last dialysis treatment						
15	If deceased ever received a transpl			16	3 \	Nas natient receivin	nd Hospice care prior
10.	•	ai it.	/ / nu			•	ig Hospice care prior
	•	Month			١	o dodin.	
	b. Type of transplant received						
	☐ Living Related ☐ Living Unre	elated	☐ Deceased ☐ Unknow	wn		Yes	No
	c. Was graft functioning (nation) not on	dialve	is) at time of death?				
						Unknown	
	•						
		onic n	· · · · · · · · · · · · · · · · · · ·	o death?			
	□ Yes □ No		☐ Unknown				
17	Name of Physician (Please print comple	te nama	18 Signature of Person (Completing 7	Thie	Form	Date
	Tamb of Frysiolari (Flease print comple	.c name	., i.s. digitatare of recisori	completing i		, , , ,,,,,,	2410

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). 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).

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 insufficiency
- 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

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. The time required to complete this information collection is estimated to average 30 minutes 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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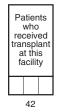
END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM ESRD FACILITY SURVEY (TRANSPLANT CENTERS ONLY)

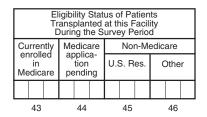
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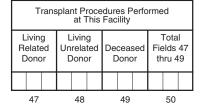
KIDNEY TRANSPLANTS PERFORMED

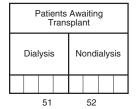
PATIENTS TRANSPLANTED AND DONOR TYPE

TO BE COMPLETED BY KIDNEY TRANSPLANT CENTERS ONLY









REMARKS/COMMENTS

COMPLETED BY (Name)

DATE

TITLE

TELEPHONE NO.