ESRD Medical Evidence Report HCFA-2728

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

A. COMPLETE FOR ALL ESRD PATIENTS

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

2. Health Insurance Claim Number	3. Social Security Number

4. Full Address *(Include City, State and Zip)*	5. Phone Number ( )
	6. Date of Birth _____/_____/_____ MM DD YYY

7. Sex _ Male_ Female	8. Ethnicity _ Hispanic: Mexican_ Hispanic: Other_ Non-Hispanic

9. Race (Check one box only) _ White_ Mid-East/Arabian _ Black_ Indian sub-Continent _ American Indian/Alaskan Native_ Other or Multiracial _ Asian_ Unknown _ Pacific Islander	10. Medical Coverage (Check all that apply) a. _ Medicaide. _ Other Medical Insurance b. _ DVAf. _ None c. _ Medicare d. _ Employer Group Health Insurance

11. Is Patient Applying for ESRD Medicare Coverage? (if YES, enter address or social security office)
ADDRESS
_ Yes_ No

CITYSTATEZIP

12. Primary Cause of Renal Failure *(Use code from back of form)*	13. Height		14. Dry Weight	

	INCHES OR CENTIMETERS	POUNDS OR KILOGRAMS

15. Employment Status (6 mos prior and current status)	16. Co-Morbid Conditions (Check **ALL** that apply currently or during last 10 years) *See instructions

Prior	Current		a.	_	Congestive heart failure	k.	_	Diabetes, currently on insulin
			b.	_	Ischemic heart disease, CAD*	l.	_	Chronic obstructive pulmonary disease
_	_	Unemployed	c.	_	Myocardial infraction	m.	_	Tobacco use (current smoker)
_	_	Employed Full Time	d.	_	Cardiac arrest	n.	_	Malignant neoplasm, Cancer
_	_	Employed Part Time	e.	_	Cardiac dysrhythmia	o.	_	Alcohol dependence
_	_	Homemaker	f.	_	Pericarditis	p.	_	Drug dependence*
_	_	Retired due to Age/Preference	g.	_	Cerebrovascular disease, CVA, TIA*	q.	_	HIV positive status_ Can't Disclose
_	_	Retired (Disability)	h.	_	Peripheral vascular disease*	r.	_	AIDS_ Can't Disclose
_	_	Medical Leave of Absence	i.	_	History of hypertension	s.	_	Inability to ambulate
_	_	Student	j.	_	Diabetes (primary or contributing)	t.	_	Inability to transfer

17. Was pre-dialysis/transplant EPO administered?
_ Yes_ No

18.Laboratory Values Prior to First Dialysis Treatment or Transplant *See instructions

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Hematocrit (%)			e. Serum Creatinine (mg/dl)		
b. Hemoglobin (g/dl)*			f. Creatinine Clearance (ml/min)*		
c. Serum Albumin (g/dl)			g. BUN (mg/dl)*		
d. Serum Albumin Lower Limit (g/dl)			h. Urea Clearance (ml/min)*		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT.

19. Name of Provider	20. Medicare Provider Number
21. Primary Dialysis Setting _ Hospital Inpatient _ Dialysis Facility Center_ Home	22. Primary Type of Dialysis _ Hemodialysis_ IPD_ CAPD_ CCPD_ Other
23. Date Regular Dialysis Began _____/_____/_____ MMDDYY	24. Date Patient Started at Current Facility _____/_____/_____ MMDDYY

25. Date Dialysis Stopped _____/_____/_____ MMDDYY	26. Date of Death _____/_____/_____ MMDDYY

ESRD Medical Evidence Report (back)

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant _____/_____/_____ MM DD YY	28. Name of Transplant Hospital	29. Medicare Provider Name for Item 26

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.

30. Enter Date _____/_____/_____ MM DD YY	31. Name of Preparation Hospital	32. Medicare Provider Number for Item 31

33. Current Status of Transplant
_ Functioning_ Non-Functioning

34. If Nonfunctioning, Date of Return To Regular Dialysis _____/_____/_____ MM DD YY	35. Current Dialysis Treatment Site _ Hospital Inpatient_ Dialysis Facility/Center_ Home

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

36. Name of Training Provider	37. Medicare Provider Number of Training Provider
38. Date Training Began _____/_____/_____ MM DD YY	39. Type of Training _ Hemodialysis_ IPD_ CAPD_ CCPD
40. This Patient is Expected to Complete *(or has completed*) Training and Will Self-dialyze on a Regular Basis. _ Yes_ No	41. Date When Patient Completed, or is Expected to Complete, Training _____/_____/_____ MM DD YY

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.

42. Printed Name and Signature of Physician personally familiar with the patient's training	43. UPIN of Physician in Item 42

E. PHYSICIAN IDENTIFICATION

44. Attending Physician *(Print)*	45. Physician's Phone No. ( )	46. UPIN of Physician in Item 44

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.

47. Attending Physician's Signature of Attestation (Same as Item 44)	48. Date _____/_____/_____ MM DD YY

49. 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 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.

50. Signature of Patient *(Signature by mark must be witnessed)*	51. Date _____/_____/_____ MM DD YY

G. PRIVACY ACT 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 Privacy Act Issuance, 1991 Compilation, Vol. 1, pages 436-437, December 31, 1991 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 a research, demonstrator, evaluator, or epidermiologic project related to the prevention of disease or disability, or the restoration of 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.

H. FOR ESRD NETWORK USE ONLY IN CASES REFERRED TO ESRD MEDICAL REVIEW BOARD

52. Network Confirmed as ESRD _ Yes_ No	53. Authorized Signature	54. Date _____/_____/_____ MM DD YY	55. Network Number