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

Form Approved
OMB No. 0938-0046
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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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