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

OMB#0938-0046

Social Worker

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)*

2. Medicare Claim Number

3. Social Security Number

4. Date of Birth ___/___/___ MM DD YYYY

5. Patient Mailing Address *(Include City, State and Zip)*

6. Phone Number ( )

7. Sex ☐ Male ☐ Female

8. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander*
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe _____

11. Is patient applying for ESRD Medicare coverage?
☐ Yes ☐ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ HMO/M+C ☐ Other ☐ None

13. Height
INCHES _____ OR
CENTIMETERS _____

14. Dry Weight
POUNDS _____ OR
KILOGRAMS _____

15. Primary Cause of Renal Failure *(Use code from back of form)*

Doctor

16. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instruct

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
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

Nurse

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent?	☐ Yes	☐ No	☐ Unknown	If Yes, answer:	☐ 6-12 months	☐ >12 months
b. Was patient under care of a nephrologist?	☐ Yes	☐ No	☐ Unknown	If Yes, answer:	☐ 6-12 months	☐ >12 months
c. Was patient under care of kidney dietitian?	☐ Yes	☐ No	☐ Unknown	If Yes, answer:	☐ 6-12 months	☐ >12 months
d. What access was used on first outpatient dialysis:	☐ AVF	☐ Graft	☐ Catheter	☐ Other		
If not AVF, then: Is maturing AVF present?	☐ Yes	☐ No				
Is maturing graft present?	☐ Yes	☐ No				

You can add < 6 months here

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

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	___ ___ ___	

Lipid Ranges:
Lipid TC: 100-240
LDL: 100-190
HDL: 35 – 60
TG: 100-1000

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

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

23. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

Doctor

24. Date Regular Chronic Dialysis Began ___/___/___ MM DD YYYY

25. Date Patient Started Chronic Dialysis at Current Facility ___/___/___ MM DD YYYY

26. Has patient been informed of kidney transplant options?
☐ Yes ☐ No

Doctor

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

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Contact Network for Transplant dates

C. COMPLETE FOR ALL KIDNEY 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 inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32
__/__/____ MM DD YYYY		

34. Current Status of Transplant *(if functioning, skip items 36 and 37)* ☐ Functioning ☐ Non-Functioning	35. Type of Donor: ☐ Deceased ☐ Living Related ☐ Living Unrelated
36. If Non-Functioning, Date of Return to Regular Dialysis __/__/____ MM DD YYYY	37. Current Dialysis Treatment Site ☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

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

PD Nurse

38. Name of Training Provider	39. Medicare Provider Number of Training Provider (for Item 38)
40. Date Training Began __/__/____ MM DD YYYY	41. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
42. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	43. 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.

44. Printed Name and Signature of Physician personally familiar with the patient's training	45. UPIN of Physician in Item 44
a.) Printed Name b.) Signature c.) Date __/__/____ MM DD YYYY	

Training Doctor

E. PHYSICIAN IDENTIFICATION

Supervising Doctor

46. Attending Physician *(Print)*	47. Physician's Phone No. ( )	48. UPIN of Physician in Item 46

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.

49. Attending Physician's Signature of Attestation *(Same as Item 46)*	50. Date __/__/____ MM DD YYYY
51. Physician Recertification Signatu[re]	52. Date __/__/____ MM DD YYYY

For patients who initially did NOT file for Medicare

53. 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.

If your Patient is deceased or refuses to sign, please note here

d.)	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.