

ESRD Entitlement/Registration (Form 2728) File

PUBLICID

NCHS Public ID

Numeric identifier given by NCHS to allow for linkage between NCHS surveys and CMS files.

Type: Character **Width:** 15

Usage Notes:

See [Appendix A](#) for NCHS survey specific descriptions. Researchers linking to the NHEFS, NHANES II, and NHANES III surveys should use SEQN.

SEQN

Survey Participant Identification Number

Numeric identifier given by NCHS to allow for linkage between NCHS surveys and CMS files.

Type: Numeric **Width:** 8

Usage Notes:

See [Appendix A](#) for NCHS survey specific descriptions. This variable is only available on NHEFS, NHANES II, and NHANES III data files.

FORMDATE

2728 Form Update Date

Date 2728 form was entered into the system.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1967-09-01 - 2000-12-31

Usage Notes:

The data for all variables on this file was obtained from [CMS Form 2728 – ESRD Medical Evidence Report Medicare Entitlement and/or Registration Form](#). Some participants may have 2 or more completed 2728 forms. The earliest data corresponds to the initial ESRD entitlement prior to stopping dialysis and restarting.

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FORMSTATUS

2728 Form Status Indicator

The current status of the 2728 form in the queue.

Type: Character **Width:** 1

Possible Values:

T = Transmitted
V = Validated Ready
W = Validated Wait
Q = Queued
S = Saved

DOB

Patient Date of Birth

ESRD patient's date of birth.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1901-02-09 - 2000-12-31

GENDER

Patient Gender

ESRD patient's gender.

Type: Character **Width:** 1

Possible Values:

1 = Male
2 = Female

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ETHNICITY

Patient Ethnicity

Ethnicity of ESRD patient

Type: Character **Width:** 1

Possible Values:

- 1 = Hispanic-Mexican
- 2 = Hispanic-Other
- 3 = Non-Hispanic
- 4 = Unknown
- 5 = Hispanic-Non Specified

Usage Notes:

There may be inconsistencies between the values of the ethnicity variables on the NCHS survey files and the ESRD linked data files. Researchers should use this variable with caution.

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RACE

Patient Race

Race of ESRD patient.

Type: Numeric **Width:** 4

Possible Values:

- 1 = American Indian/Alaskan Native
- 2 = Asian
- 3 = Black
- 4 = White
- 5 = Unknown
- 6 = Pacific Islander
- 7 = Middle Eastern Arabian
- 8 = Indian subcontinent
- 9 = Other/Multi-racial

Usage Notes:

This variable contains some values of '0'. There is no definition available for '0' values. There may be inconsistencies between the values of the race variable on the NCHS survey files and the ESRD linked data files. Researchers should use this variable with caution.

MEDICAID

Medicaid Indicator

Indicates whether the patient is receiving state Medicaid benefits at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

- Y = Yes
 - N = No
-

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MEDDVA

Veterans Affairs (VA) Indicator

Indicates whether the patient is receiving medical care from a Department of Veterans Affairs facility.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MEDICARE

Medicare Indicator

Indicates whether the patient is entitled to Federal Medicare benefits at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MEDGROUP

Group Health Plan Indicator

Indicates whether the patient receives medical benefits through an employer group health plan that covers employees, former employees, or the families of employees or former employees at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

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MEDOTHER

Other Health Plan Indicator

Indicates that the patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, nor an employer group health insurance plan at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MEDNONE

No Insurance Indicator

Indicates that the patient has no medical insurance plan at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PATAPPLY

ESRD Applying Indicator

Indicates whether the patient is applying for ESRD Medicare.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

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PRIMDIAG

Patient Primary ESRD Diagnosis

Patient's primary cause of End Stage Renal Disease.

Type: Character **Width:** 5

Usage Notes:

This variable is coded based on ICD-9-CM codes.

PRIMTRAIL

Patient Primary ESRD Diagnosis Trailer

The trailer for the patient's primary cause of End Stage Renal Disease.

Type: Character **Width:** 1

Usage Notes:

This variable is coded based on ICD-9-CM codes.

PRIMCAUS

Patient Primary Cause of ESRD

PRIMDIAG and PRIMTRAIL combined.

Type: Character **Width:** 6

Usage Notes:

This variable is coded based on ICD-9-CM codes.

HEIGHT

Patient Height

The most recent recorded height of the patient at time of 2728 filing or if an amputee, height before amputation.

Type: Numeric **Width:** 4

Possible Values: 0 - 198

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HEIGHTUNIT

Unit of Height Measurement

Unit of Height Measurement.

Type: Character **Width:** 1

Possible Values:

I = Inches
C = Centimeters

WEIGHT

Patient Weight

The most recent recorded weight of the patient at time of 2728 filing.

Type: Numeric **Width:** 4

Possible Values: 0 - 235

WEIGHTUNIT

Unit of Weight Measurement

Unit of Weight Measurement.

Type: Character **Width:** 1

Possible Values:

K = Kilograms
L = Pounds

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PUNEMPL

Patient Prior Unemployment Status

ESRD patient was unemployed 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PFULLTI

Patient Prior Full-time Employment Status

ESRD patient was employed full-time 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PPARTTI

Patient Prior Part-time Employment Status

ESRD patient was employed part-time 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

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PHOME

Patient Prior Homemaker Status

ESRD patient was a homemaker 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PRETAG

Patient Prior Retirement Status

ESRD patient was retired due to age/preference 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PRETDIB

Patient Prior Disability Status

ESRD patient was retired due to disability 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

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PMEDLOA

Patient Prior Medical Leave Status

ESRD patient was on a medical leave of absence 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

PSTUDENT

Patient Prior Student Status

ESRD patient was a student 6 months prior to the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

CUNEMPL

Patient Current Unemployment Status

ESRD patient was unemployed at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

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CFULLTI

Patient Current Full-time Employment Status

ESRD patient was employed full-time at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

CPARTTI

Patient Current Part-time Employment Status

ESRD patient was employed part-time at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

CHOME

Patient Current Homemaker Status

ESRD patient was a homemaker at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

CRETAGE

Patient Current Retirement Status

ESRD patient was retired due to age/preference at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

CRETDIB

Patient Current Disability Status

ESRD patient was retired due to disability at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

CMEDLOA

Patient Current Medical Leave Status

ESRD patient was on a medical leave of absence at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

CSTUDENT

Patient Current Student Status

ESRD patient was a student at the time of 2728 filing.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDA

Patient Congestive Heart Failure Indicator

ESRD patient suffered from congestive heart failure at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDB

Patient Ischemic Heart Disease Indicator

ESRD patient suffered from ischemic heart disease at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

MORBIDC

Patient Myocardial Infarction Indicator

ESRD patient suffered from myocardial infarction at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDD

Patient Cardiac Arrest Indicator

ESRD patient suffered from cardiac arrest at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDE

Patient Cardiac Dysrhythmia Indicator

ESRD patient suffered from cardiac dysrhythmia at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

MORBIDF

Patient Pericarditis Indicator

ESRD patient suffered from cardiac pericarditis at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDG

Patient Cerebrovascular Disease Indicator

ESRD patient suffered from cerebrovascular disease at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

Usage Notes:

This variable includes history of stroke/cerebrovascular accident (CVA) and transient ischemic attack (TIA).

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MORBIDH

Patient Peripheral Vascular Disease (PVD) Indicator

ESRD patient suffered from peripheral vascular disease at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

Usage Notes:

This variable includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

MORBIDI

Patient Hypertension Indicator

ESRD patient suffered from hypertension at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

MORBIDJ

Patient Diabetes (Primary or Contributing) Indicator

ESRD patient suffered from diabetes (primary or contributing) at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDK

Patient Diabetes (on Insulin) Indicator

ESRD patient suffered from diabetes (on insulin) at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDL

Patient Chronic Obstructive Pulmonary Disease Indicator

ESRD patient suffered from chronic obstructive pulmonary disease at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

MORBIDM

Patient Tobacco Use (Current Smoker) Indicator

ESRD patient suffered from tobacco use (current smoker) at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDN

Patient Cancer Indicator

ESRD patient suffered from malignant neoplasm/cancer at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDO

Patient Alcohol Dependence Indicator

ESRD patient suffered from alcohol dependence at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

MORBIDP

Patient Drug Dependence Indicator

ESRD patient suffered from drug dependence at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDQ

Patient HIV Indicator

ESRD patient suffered from HIV positive status at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

U = Unknown

MORBIDR

Patient AIDS Indicator

ESRD patient suffered from acquired immune deficiency syndrome (AIDS) at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

U = Unknown

ESRD Entitlement/Registration (Form 2728) File

MORBIDS

Patient Inability to Ambulate Indicator

ESRD patient suffered from inability to ambulate at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

MORBIDT

Patient Inability to Transfer Indicator

ESRD patient suffered from inability to transfer at time of 2728 filing or within the prior 10 years.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

EPO

Patient Erythropoietin (EPO) Indicator

Indicates whether erythropoietin (EPO) was administered to the patient prior to dialysis treatments or kidney transplant.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

IHECRIT

Patient Hematocrit Value

ESRD patient's hematocrit value.

Type: Numeric **Width:** 8

Possible Values: 0 – 99.999999

Usage Notes:

Some values may contain a decimal.

IHECRITDTE

Date of Hematocrit Value Collection

Date the hematocrit value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1994-11-22 - 2000-12-31

IHEGLO

Patient Hemoglobin Value

ESRD patient's hemoglobin value.

Type: Numeric **Width:** 8

Possible Values: 0 – 99.999999

Usage Notes:

Some values may contain a decimal.

IHEGLODTE

Date of Hemoglobin Value Collection

Date the hemoglobin value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1987-12-08 - 2000-12-31

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ALBUMIN

Patient Serum Albumin Value

ESRD patient's serum albumin value.

Type: Numeric **Width:** 8

Possible Values: 0 – 9.9999999

Usage Notes:

Some values may contain a decimal.

ALBUMDTE

Date of Serum Albumin Value Collection

Date the serum albumin value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1944-12-28 - 2000-12-31

ALBUMINLL

Serum Albumin Lower Limit Value

The serum albumin lower limit of the normal range for the lab that did the patient's test.

Type: Numeric **Width:** 8

Possible Values: 0 – 9.9999999

Usage Notes:

Some values may contain a decimal.

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ISERCREA

Patient Serum Creatine Value

ESRD patient's serum creatine value.

Type: Numeric **Width:** 8

Possible Values: 0 – 99.9

Usage Notes:

Some values may contain a decimal.

ISERDTE

Date of Serum Creatine Value Collection

Date the serum creatine value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1994-12-27 - 2000-12-31

ICREACLEAR

Patient Creatine Clearance Value

ESRD patient's creatine clearance value.

Type: Numeric **Width:** 8

Possible Values: 0 – 99.999999

Usage Notes:

Some values may contain a decimal.

ICERDTE

Date of Creatine Clearance Value Collection

Date the serum creatine clearance value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1994-11-03 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

IBUN

Patient Blood Urea Nitrogen (BUN) Value

ESRD patient's blood urea nitrogen (BUN) value.

Type: Numeric **Width:** 8

Possible Values: 0 – 227

IBUNDTE

Date of Blood Urea Nitrogen (BUN) Value Collection

Date the blood urea nitrogen (BUN) value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1994-12-28 - 2000-12-31

IUREA

Patient Urea Clearance Value

ESRD patient's urea clearance value.

Type: Numeric **Width:** 8

Possible Values: 0 – 9.9999999

IUREADTE

Date of Urea Clearance Value Collection

Date the urea clearance value was taken.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1995-09-27 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

DIALSET

Patient Dialysis Setting

The anticipated long term treatment setting for the patient at the time the 2728 form was completed

Type: Character **Width:** 1

Possible Values:

- 1 = Hospital Inpatient
 - 2 = Dialysis Center/Facility
 - 3 = Home
 - 4 = Unknown
-

DIALTYPE

Dialysis Type

The anticipated long term primary type of dialysis for the patient at the time the 2728 form was completed

Type: Character **Width:** 1

Possible Values:

- 1 = HEMO
 - 2 = IPD
 - 3 = CAPD
 - 4 = CCPD
 - 5 = Other
 - 6 = Unknown
-

DATEBEGAN

Date of Dialysis Began

Date the regular course of dialysis began.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1977-12-31 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

DATEHERE

Date Patient Started at 2728 Provider

Date the patient started at the dialysis provider listed on the 2728 form.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1980-11-10 - 2000-12-31

DATESTOP

Date Patient Stopped Dialysis Therapy

Date the patient stopped dialysis therapy.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1997-04-05 - 2000-12-31

DATEDEATH

Patient Date of Death

Date of ESRD patient's death.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1982-01-13 - 2000-12-31

TRANSDATE

Date of Most Recent Transplant

Date of patient's most recent kidney transplant at time the 2728 form was completed.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1980-09-18 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

ENTDATE

Date Patient Entered Prep Hospital

Date the patient was admitted as an inpatient to a hospital in preparation for, or anticipation of a kidney transplant.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1967-09-23 - 2000-12-31

TRANSTATUS

Transplant Status

The status of the kidney transplant at the time the 2728 form was completed

Type: Character **Width:** 1

Possible Values:

- 1 = Functioning
- 2 = Rejected
- 3 = Unknown

Usage Notes:

This variable contains some values of '0'. There is no definition available for a value of '0'.

DIALRETDAT

Dialysis Return Date

Date the patient returned to regular course of dialysis after a transplant rejection.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1987-07-14 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

TREATSITE

Treatment Site

The current dialysis treatment site of the patient after a transplant rejection at the time the 2728 form was completed.

Type: Character **Width:** 1

Possible Values:

- 1 = Hospital Inpatient
- 2 = Dialysis Facility/Center
- 3 = Home
- 4 = Unknown

Usage Notes:

This variable contains some values of '0'. There is no definition available for a value of '0'.

TRAINDATE

Dialysis Training Begin Date

Date self-dialysis training began.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1984-03-19 - 2000-12-31

TRRAINTYPE

Self Dialysis Training Type

The type of self-dialysis the patient began.

Type: Character **Width:** 1

Possible Values:

- 1 = Hemodialysis
 - 2 = IPD
 - 3 = CAPD
 - 4 = CCPD
-

ESRD Entitlement/Registration (Form 2728) File

TRAINCERT

Training Completion Indicator

Indicates whether physician certified that patient completed self-dialysis training successfully and began self-dialysis on a regular basis.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

TRAINEND

Dialysis Training End Date

Date patient completed self-dialysis training.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1989-09-29 - 2000-12-31

ENTERDATE

Supervising Physician Signature Date

Date the physician signed the 2728 form.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1978-03-21 - 2000-12-31

PATSIGNDAT

Patient Signature Date

Date the ESRD patient signed the 2728 form.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1929-11-29 - 2000-12-31

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NWCERT

Network Confirmation Indicator

Indicates whether the Network confirmed the patient as ESRD.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

NWDATE

Network Action Date

Date the Network took action on the 2728 form.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1989-02-03 - 2000-12-31

DECISION

ESRD Decision

The basis for the decision regarding how the patient was confirmed as ESRD.

Type: Character **Width:** 1

Possible Values:

1 = Passed Guidelines

2 = Passed MRB

3 = Failed MRB

4 = Passed because Patient Died within 1st 3 months

5 = Passed because Patient has no Kidneys

6 = Failed, under MRB Review

7 = Passed on Age

Usage Notes:

This variable contains some values of '0'. There is no definition available for a value of '0'.

ESRD Entitlement/Registration (Form 2728) File

INHOSP

Patient Hospitalization Indicator

Indicates whether patient was admitted to prior to transplant.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

SDBDATE

Form Received Date

Date the Network received the 2728 form for ESRD patient.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1980-12-10 - 2000-12-31

TXTFILEDATE

Form Transmit Action Date

Date the 2728 form was transmitted to the Central Repository.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1980-12-10 - 2000-12-31

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ACCURATE

Accuracy Indicator

Indicates whether the 2728 form passed accuracy test.

Type: Numeric **Width:** 4

Possible Values:

0 = Not Accurate

1 = Accurate

ONTIME

Timeliness Indicator

Indicates whether the 2728 form was received within HCFA timeliness guidelines.

Type: Numeric **Width:** 4

Possible Values:

0 = Late

1 = Timely

RTFDATE

Date Form Returned to Facility

Date the 2728 form was returned to the facility for incomplete information.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1996-05-20 - 2000-12-31

CFDATE

Date Corrected Form Received

Date the completed or corrected 2728 form was returned to the facility.

Type: Character **Width:** 10 **Format:** YYYY-MM-DD

Possible Values: 1995-10-05 - 2000-12-31

ESRD Entitlement/Registration (Form 2728) File

ERRORS

2728 Form Errors

Indicates error(s) that display on the compliance report.

Type: Character **Width:** 50

Usage Notes:

There are no definitions available for the values contained in this variable. Researchers should use this variable with caution.

REJECTREPORT

Reject Report Indicator

Indicates whether a reject report was generated for the 2728 form.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

SUPPFORM

Supplemental Form Indicator

Indicates whether the form was a supplemental form.

Type: Character **Width:** 1

Possible Values:

Y = Yes

N = No

ESRD Entitlement/Registration (Form 2728) File

GFR

Glomerular Filtration Rate

Glomerular Filtration Rate.

Type: Numeric **Width:** 8

Possible Values: 0 - 99.99

Usage Notes:

Some values may contain a decimal.

Appendix A: Data Usage Issues Regarding Public ID/SEQN

ESRD Entitlement/Registration (Form 2728) File

Data Usage Issues regarding Public ID/SEQN

The data provided on the 1994-1998 NHIS, NHEFS, NHANES II, NHANES III, and LSOA III linked CMS Medicare files can be merged with the NCHS public use survey data files using the unique survey specific Public Identification number (PUBLIC ID/SEQN). Note: At this time the linked Medicare data files are only available for research use through the NCHS restricted access data center (RDC). Approved RDC researchers may choose to provide their own analytic files created from public use survey files to the RDC. Therefore, it is important for researchers to include survey specific Public Identification number on any analytic files sent to the RDC. The RDC will merge data (using PUBLIC ID or SEQN) from the linked CMS Medicare files to the analyst's file. The merged file will be held at the RDC and made available for analysis. Information on how to identify and/or construct the NCHS survey specific PUBLIC ID or SEQN is provided below.

I. National Health Interview Survey (NHIS)

On the NHIS surveys, researchers need to construct the NHIS public id from the following variables. The number and public-use location varies by NHIS survey year.

NHIS 1994

<u>Item</u>	<u>Public-use Location</u>	<u>Length</u>	<u>Description</u>
Year (2 digit)	3-4	2	Year of interview
Quarter	5	1	Calendar quarter of interview
PSU	6-8	3	Random recode of PSU #
Week	9-10	2	Week of interview within quarter
Segment	11-12	2	Segment number
Household	13-14	2	Household number within quarter
Person number	15-16	2	Person number within household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

NHIS 1995, 1996

<u>Item</u>	<u>Public-use Location</u>	<u>Length</u>	<u>Description</u>
Year (2 digit)	3-4	2	Year of interview
Household ID	5-14	10	Household ID number
Person number	15-16	2	Person number within Household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

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NHIS 1997-1998

<u>Item</u>	<u>Location</u>	<u>Length</u>	<u>Description</u>
Year (4 digit)	3-6	4	Year of interview
Household Serial #	7-12	6	Household serial number
Person number	15-16	2	Person number within Household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

II. NHANES I Epidemiologic Follow-up Study NHEFS

<u>Item</u>	<u>Length</u>	<u>Description</u>
SEQN	5	Participant identification number

All of the NHEFS public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHEFS Files to the NHEFS-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.

III. Second National Health and Nutrition Examination Survey (NHANES II)

<u>Item</u>	<u>Length</u>	<u>Description</u>
SEQN	5	Participant identification number

All of the NHANES II public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHANES II Files to the NHANES II-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.

IV. Third National Health and Nutrition Examination Survey (NHANES III)

<u>Item</u>	<u>Length</u>	<u>Description</u>
SEQN	5	Participant identification number

All of the NHANES III public-use data files are linked with the common survey participant identification number (SEQN). Merging information from multiple NHANES III Files to the NHANES III-CMS linked files using this variable ensures that the appropriate information for each survey participant is linked correctly.

ESRD Entitlement/Registration (Form 2728) File

V. The Second Longitudinal Study of Aging (LSOA II)

On the LSOA II survey, researchers need to construct the LSOA II public id from the following variables.

LSOA II

<u>Item</u>	<u>Public-use Location</u>	<u>Length</u>	<u>Description</u>
Year	3-4	2	Year of interview
Quarter	5	1	Calendar quarter of interview
PSU	6-8	3	Random recode of PSU #
Week	9-10	2	Week of interview within quarter
Segment	11-12	2	Segment number
Household	13-14	2	Household number within quarter
Person number	15-16	2	Person number within household

Note: Concatenate all variables to get the unique person identifier. All variables are zero filled.

ESRD Entitlement/Registration (Form 2728) File

Appendix B: ESRD Medical Evidence Report Medicare Entitlement and/or Registration Form (Form 2728)

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 _____ *complete Item 9

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 Medicare Advantage 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)

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

Prior	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Unemployed
<input type="checkbox"/>	<input type="checkbox"/>	Employed Full Time
<input type="checkbox"/>	<input type="checkbox"/>	Employed Part Time
<input type="checkbox"/>	<input type="checkbox"/>	Homemaker
<input type="checkbox"/>	<input type="checkbox"/>	Retired due to Age/Preference
<input type="checkbox"/>	<input type="checkbox"/>	Retired (Disability)
<input type="checkbox"/>	<input type="checkbox"/>	Medical Leave of Absence
<input type="checkbox"/>	<input type="checkbox"/>	Student

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

a. <input type="checkbox"/> Congestive heart failure	n. <input type="checkbox"/> Malignant neoplasm, Cancer
b. <input type="checkbox"/> Atherosclerotic heart disease ASHD	o. <input type="checkbox"/> Toxic nephropathy
c. <input type="checkbox"/> Other cardiac disease	p. <input type="checkbox"/> Alcohol dependence
d. <input type="checkbox"/> Cerebrovascular disease, CVA, TIA*	q. <input type="checkbox"/> Drug dependence*
e. <input type="checkbox"/> Peripheral vascular disease*	r. <input type="checkbox"/> Inability to ambulate
f. <input type="checkbox"/> History of hypertension	s. <input type="checkbox"/> Inability to transfer
g. <input type="checkbox"/> Amputation	t. <input type="checkbox"/> Needs assistance with daily activities
h. <input type="checkbox"/> Diabetes, currently on insulin	u. <input type="checkbox"/> Institutionalized
i. <input type="checkbox"/> Diabetes, on oral medications	<input type="checkbox"/> 1. Assisted Living
j. <input type="checkbox"/> Diabetes, without medications	<input type="checkbox"/> 2. Nursing Home
k. <input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> 3. Other Institution
l. <input type="checkbox"/> Chronic obstructive pulmonary disease	v. <input type="checkbox"/> Non-renal congenital abnormality
m. <input type="checkbox"/> Tobacco use (current smoker)	w. <input type="checkbox"/> None

18. Prior to ESRD therapy:

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

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	___ . ___	

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

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

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 KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant MM / DD / YYYY	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29
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 MM / DD / YYYY	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32
34. Current Status of Transplant (if functioning, skip items 36 and 37) <input type="checkbox"/> Functioning <input type="checkbox"/> Non-Functioning	35. Type of Donor: <input type="checkbox"/> Deceased <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated	
36. If Non-Functioning, Date of Return to Regular Dialysis MM / DD / YYYY	37. Current Dialysis Treatment Site <input type="checkbox"/> Home <input type="checkbox"/> Dialysis Facility/Center <input type="checkbox"/> SNF/Long Term Care Facility	

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

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 <input type="checkbox"/> Hemodialysis a. <input type="checkbox"/> Home b. <input type="checkbox"/> In Center <input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other	
42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis. <input type="checkbox"/> Yes <input type="checkbox"/> 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 a.) Printed Name b.) Signature c.) Date MM / DD / YYYY	45. UPIN of Physician in Item 44
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E. PHYSICIAN IDENTIFICATION

46. Attending Physician (Print)	47. Physician's Phone No. ()	48. UPIN of Physician in Item 46
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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 Signature	52. Date MM / DD / YYYY
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.

54. Signature of Patient (Signature by mark must be witnessed.)	55. Date MM / DD / YYYY
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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.**

ICD-9	NARRATIVE	ICD-9	NARRATIVE
DIABETES		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)
GLOMERULONEPHRITIS		75316	Medullary cystic disease, including nephronophthisis
5829	Glomerulonephritis (GN) (histologically not examined)	7595	Tuberous sclerosis
5821	Focal glomerulosclerosis, focal sclerosing GN	7598	Hereditary nephritis, Alport's syndrome
5831	Membranous nephropathy	2700	Cystinosis
58321	Membranoproliferative GN type 1, diffuse MPGN	2718	Primary oxalosis
58322	Dense deposit disease, MPGN type 2	2727	Fabry's disease
58381	IgA nephropathy, Berger's disease (proven by immunofluorescence)	7533	Congenital nephrotic syndrome
58382	IgM nephropathy (proven by immunofluorescence)	5839	Drash syndrome, mesangial sclerosis
5834	With lesion of rapidly progressive GN	75321	Congenital obstruction of ureteropelvic junction
5800	Post infectious GN, SBE	75322	Congenital obstruction of ureterovesical junction
5820	Other proliferative GN	75329	Other Congenital obstructive uropathy
SECONDARY GN/VASCULITIS		7530	Renal hypoplasia, dysplasia, oligonephronia
7100	Lupus erythematosus, (SLE nephritis)	75671	Prune belly syndrome
2870	Henoch-Schonlein syndrome	75989	Other (congenital malformation syndromes)
7101	Scleroderma	NEOPLASMS/TUMORS	
28311	Hemolytic uremic syndrome	1890	Renal tumor (malignant)
4460	Polyarteritis	1899	Urinary tract tumor (malignant)
4464	Wegener's granulomatosis	2230	Renal tumor (benign)
58392	Nephropathy due to heroin abuse and related drugs	2239	Urinary tract tumor (benign)
44620	Other Vasculitis and its derivatives	23951	Renal tumor (unspecified)
44621	Goodpasture's syndrome	23952	Urinary tract tumor (unspecified)
58391	Secondary GN, other	20280	Lymphoma of kidneys
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS		20300	Multiple myeloma
9659	Analgesic abuse	20308	Other immuno proliferative neoplasms (including light chain nephropathy)
5830	Radiation nephritis	2773	Amyloidosis
9849	Lead nephropathy	99680	Complications of transplanted organ unspecified
5909	Nephropathy caused by other agents	99681	Complications of transplanted kidney
27410	Gouty nephropathy	99682	Complications of transplanted liver
5920	Nephrolithiasis	99683	Complications of transplanted heart
5996	Acquired obstructive uropathy	99684	Complications of transplanted lung
5900	Chronic pyelonephritis, reflux nephropathy	99685	Complications of transplanted bone marrow
58389	Chronic interstitial nephritis	99686	Complications of transplanted pancreas
58089	Acute interstitial nephritis	99687	Complications of transplanted intestine
5929	Urolithiasis	99689	Complications of other specified transplanted organ
27549	Other disorders of calcium metabolism	MISCELLANEOUS CONDITIONS	
HYPERTENSION/LARGE VESSEL DISEASE		28260	Sickle cell disease/anemia
40391	Unspecified with renal failure	28269	Sickle cell trait and other sickle cell (HbS/Hb other)
4401	Renal artery stenosis	64620	Post partum renal failure
59381	Renal artery occlusion	042	AIDS nephropathy
59383	Cholesterol emboli, renal emboli	8660	Traumatic or surgical loss of kidney(s)
		5724	Hepatorenal syndrome
		5836	Tubular necrosis (no recovery)
		59389	Other renal disorders
		7999	Etiology uncertain

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

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:

Check the appropriate block 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

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 15, 17-18, 26-27, 49-50: To be completed by the attending physician.

Item 44: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.

Items 54 and 55: To be signed and dated by the patient.

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.

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 Medicare claim number as it appears on his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
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 home area code and telephone number.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

Hispanic or Latino—A person of Cuban, Puerto Rican, or Mexican culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

9. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 8.

10. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

White—A person having origins in any of the original white peoples of Europe, the Middle East or North Africa.

Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

American Indian/Alaska Native—A person having origins in any of the original peoples of North America and South America (including Central America) and who maintains tribal affiliation or community attachment. Print the name of the enrolled or principal tribe to which the patient claims to be a member.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.

DISTRIBUTION OF COPIES:

- Forward the first part (blue) of this form to the Social Security office servicing the claim.
 - Forward the second part (green) of this form to the ESRD Network Organizations.
 - Retain the last part (white) in the patient's medical records file.
-

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 is 0938-0046. The time required to complete this information collection estimated to average 45 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, Attention: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

11. Check the appropriate yes or no block 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.**

12. Check **all** the blocks that apply to this patient's current medical insurance status.

Medicaid—Patient is currently receiving State Medicaid benefits.

Medicare—Patient is currently entitled to Federal Medicare benefits.

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.

DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

None—Patient has no medical insurance plan.

13. 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.

14. 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.

15. **To be completed by the attending physician.** Enter the ICD-9-CM from back of form to indicate the primary cause of end stage renal disease. These are the only acceptable causes of end stage renal disease.

16. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. **Check only one box for each time period.** If patient is under 6 years of age, leave blank.

17. **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** includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

***Drug dependence** means dependent on illicit drugs.

18. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received Exogenous erythropoetin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, 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 maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 19a thru 19c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

19a1. Enter the 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.

19a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

19a3. Enter the serum albumin lab method used (BCG or BCP).

19b. 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.

19c. 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.

19d. 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.

19e. Enter the Lipid Profile values and date test was taken. These values: TC—Total Cholesterol; LDL—LDL Cholesterol; HDL—HDL Cholesterol; TG—Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

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

21. Enter the 6-digit Medicare identification code of the dialysis facility in item 20.

22. 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.

23. 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 hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. **Check only one block.** 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.

24. 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 ability to remove or adjust blood wastes that in order to maintain life he or she 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 53, that patient is restarting dialysis.

25. 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 24.

26. Enter whether the patient has been informed of their options for receiving a kidney transplant.

27. If the patient has not been informed of their options (answered "no" to Item 26), then enter all reasons why a kidney transplant was not an option for this patient at this time.
 28. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.
 29. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 28.
 30. Enter the 6-digit Medicare identification code of the hospital in Item 29 where the patient received a kidney transplant on the date entered in Item 28.
 31. 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.
 32. 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.
 33. Enter the 6-digit Medicare identification number for hospital in Item 32.
 34. Check the appropriate functioning or non-functioning block.
 35. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.
 36. 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.
 37. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting.
- 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 38-43 if the patient has entered into a self-dialysis training program. Items 38-43 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.
38. Enter the name of the provider furnishing self-care dialysis training.
 39. Enter the 6-digit Medicare identification number for the training provider in Item 38.
 40. Enter the date self-dialysis training began.
 41. 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.
 42. Check the appropriate block 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.
 43. Enter date patient completed or is expected to complete self-dialysis training.
 44. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.
 45. Enter the Unique Physician Identification Number (UPIN) of physician in Item 44. (See Item 48 for explanation of UPIN.)
 46. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.
 47. 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.
 48. Enter the physician's UPIN assigned by CMS.
A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part B Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.
 49. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 46. A stamped signature is unacceptable.
 50. Enter date physician signed this form.
 51. To be signed by the physician who is currently following the patient. 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.
 52. The date physician re-certified and signed the form.
 53. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.
 54. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. **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.**
 55. The date patient signed form.

NOTICE

This form is to be completed for all End Stage Renal Disease patients beginning June 01, 2005 regardless of when the patient started dialysis or received a kidney transplant. Prior blank versions of this form should be destroyed. Old versions of the CMS-2728 will not be accepted by the Social Security Administration or the ESRD Network Organizations after May 31, 2005.
