

# 2728 – PART A

## Checkboxes for Form Type

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A. COMPLETE FOR ALL ESRD PATIENTS    *Check one:*    Initial     Re-entitlement     Supplemental

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- Initial

All Patients will only have one

- Re-Entitlement

Patient may have more than one

- Supplemental

Patient will only have one, if any

# 2728 - FIELDS 1-6

Please print name legibly

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

If no Medicare # please enter N/A

2. Medicare Claim Number

3. Social Security Number

If no SSA, Make sure you indicate this on form

Please enter **MAILING** address

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

**Please indicate if address is Nursing Home or other institution.**

# 2728 – FIELDS 8 - 10

- Ethnicity (Field 8)

8. Ethnicity

Not Hispanic or Latino     Hispanic or Latino (Complete Item 9)

- Not Hispanic or Latino

- Hispanic or Latino

- If yes, Country/Area of Origin or Ancestry (Field 9)

9. Country/Area of Origin or Ancestry

- Race (Field 10)

- Removed Other and Unknown
- American Indian/Alaskan Native
  - Added Tribal Affiliation Box

10. Race (Check all that apply)

<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander*
<input type="checkbox"/> American Indian/Alaska Native Print Name of Enrolled/Principal Tribe _____	*complete Item 9

# PART A CONTINUED

## Applying for Medicare Coverage (Field 11)

- No longer requires SSA office Address

11. Is patient applying for ESRD Medicare coverage?

Yes  No

## Medical Coverage (Field 12)

- Added HMO/M+C to coverage choices
- Mandatory field – DO NOT LEAVE BLANK

12. Current Medical Coverage *(Check all that apply)*

Medicaid  Medicare  Employer Group Health Insurance

DVA  Medicare Advantage  Other  None

## Height and Weight (Fields 13-14)

- Mandatory field – DO NOT LEAVE BLANK
- Use only whole numbers – no decimals

13. Height	14. Dry Weight
INCHES _____ OR	POUNDS _____ OR
CENTIMETERS _____	KILOGRAMS _____

– If Amputee – enter height prior to amputation

# PART A CONTINUED

## Primary Diagnosis (Field 15)

- Mandatory – **Must** use codes on back of form

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

## Employment Status(Field 16)

- Mandatory – **Must** enter one in **BOTH** columns

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

## Co-Morbid Conditions (Field 17)

- Mandatory – if “None” you must check “None”
- If you check – U-Other Institution, you must also check one, 1-3.

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

# PART A CONTINUED

## ● Pre-ESRD Therapy (Field 18)

For fields a – b – c if you answer “yes” **YOU MUST SELECT A TIME FRAME!** **UNKOWN** is not acceptable as a timeframe. **If the timeframe is “less than 6 months” you may write that in by hand**

18. Prior to ESRD therapy:

- |                                                               |                              |                                |                                   |                                |                                      |                                     |
|---------------------------------------------------------------|------------------------------|--------------------------------|-----------------------------------|--------------------------------|--------------------------------------|-------------------------------------|
| a. Did patient receive exogenous erythropoelin 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 dielilian?                | <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:         | <input type="checkbox"/> AVF | <input type="checkbox"/> Graft | <input type="checkbox"/> Catheter | <input type="checkbox"/> Other |                                      |                                     |
| If not AVF, then: Is maturing AVF present?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No    |                                   |                                |                                      |                                     |
| Is maturing graft present?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No    |                                   |                                |                                      |                                     |

Field D (all 3 parts) **MUST BE COMPLETED FOR ALL HEMODIALYSIS PATIENTS.**

- |                                                       |                              |                                |                                   |                                |
|-------------------------------------------------------|------------------------------|--------------------------------|-----------------------------------|--------------------------------|
| d. What access was used on first outpatient dialysis: | <input type="checkbox"/> AVF | <input type="checkbox"/> Graft | <input type="checkbox"/> Catheter | <input type="checkbox"/> Other |
| If not AVF, then: Is maturing AVF present?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No    |                                   |                                |
| Is maturing graft present?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No    |                                   |                                |
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# PART A CONTINUED

- Laboratory Values (Field 19)
  - Must be Within 45 days **PRIOR** to most recent ESRD episode
  - Lipid Profile Must be Within 1 year (Item e)

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	_____	_____

While every lab value is important, **SERUM CREATININE** is **MANDATORY!**

# PART B FOR ALL DIALYSIS PATIENTS

- Primary Dialysis Setting (Field 22)
  - Use “Long Term Expected Modality”
- Primary Type of Dialysis (Field 23)
  - Hemodialysis
    - MUST complete sessions per week and hours per session for all Hemodialysis patients

23. Primary Type of Dialysis

Hemodialysis (Sessions per week \_\_\_\_/hours per session \_\_\_\_)

CAPD     CCPD     Other

- Patient been informed of Transplant Options (Field 26)

If NO – MUST complete field 27

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

# **PART C – TRANSPLANT INFORMATION FOR DIALYSIS FACILITIES ONLY**

- Complete only on Re-Entitlement form for patients returning to Dialysis after a transplant failure
- If patient is unable to provide the information for part C, you may contact the Network Office for the information.
- Type of Donor (Field 35)
  - Deceased (Cadaveric)
  - Living Related
  - Living Unrelated

# PART D – HOME TRAINING

For patients completing Home Dialysis Training

- If onset modality, include on “Initial” 2728
- If going from Hemo to a home modality within the first 90 days AND applying for Medicare. This type of form should be marked “Supplemental.”

## 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>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.</i>	
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

- Physician **MUST** sign both field 44 **AND** 49.

# PART E – SIGNATURES

## Physician Attestations

- MUST be signed by Physician (Nephrologist)

### 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	

## Patient Signature:

Must be signed by patient or patient representative.

### 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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# CMS 2728 – ESRD MEDICAL EVIDENCE REPORT

- WHEN TO SUBMIT

- When a Patient has been determined to be chronic ESRD and requires a regular course of dialysis or kidney transplant to maintain life.
- If a patient goes from Incenter Hemodialysis to any home modality or receives a kidney transplant within 90 days of original onset of ESRD to request the entitlement period be waived
- If a patient has been off of dialysis more than 12 Months post recovered function event
- If a patient returns to dialysis following a transplant that has functioned for more than 36 months

# CMS 2728 – ESRD MEDICAL EVIDENCE REPORT

- WHEN **NOT** TO SUBMIT

- If a patient is ACUTE, not chronic ESRD
- If a patient changes from any home modality to another home modality within the first 90 days
- If a patient on any home modality receives a transplant within the first 90 days
- If a patient returns from dialysis from a transplant that functioned less than 36 months
- If a patient returns to dialysis less than one year from a recovered function event.