

NETWORK PATIENT ACTIVITY REPORTS

Due to the Network office on the 10th of each Month (e.g. March report is due April 10th)

- Requires Patient Zip Code on all Events
- Requires Patient Gender
- Provides Space for Summary of Additions, Losses and Neutral Event Totals

NETWORK PATIENT ACTIVITY REPORT

Please make sure you enter the correct provider
Sign the form and enter phone.

Network Patient Activity Report

PROVIDER 372540

REPORTING MONTH: _____ PHONE: _____

NAME OF PERSON COMPLETING FORM (print clearly): _____

These fields are for totals

ACTIVITY SUMMARY REPORT

Beginning Patient Count _____

of additions for the month: _____

of losses for the month: _____

Ending Patient Count _____

of modality changes: _____

Remember to write legibly!

PATIENT INFORMATION		SSN	Date of Birth	Gender	Zip Code
Last Name		Social Security Number	Date of Birth	Gender (M/F)	ZIP Code
First Name					
1					

NETWORK PATIENT ACTIVITY REPORT

ADDITIONS	LOSSES	NEUTRAL EVENTS	MODALITY	Sending/Receiving Facility
<p>ADDITION: 1=New ESRD patient (2728) 2A=Transfer In-Patient previously in Medicare Unit 2B=Transfer In - Patient New to ESRD Registry 3=Restart 4A=Dialysis After Transplant in US 4B = Dialysis After Transplant outside of US</p>	<p>LOSS: 5A=Transfer out for transplant 6A=Transfer out to another ESRD MC unit 6B=Transfer out to a non-MC unit 6C=Transfer out-Involuntary Discharge 7=Discontinue 8=Death 9=Recover Function 10=Lost to Follow Up</p>	<p>Neutral Events: 11=Modality Change 15=Interruption in Service 16=Resume Service</p>	<p>CURRENT MODALITY OF PATIENT: (Write in current Modality) Hemo Modalities In Center Hemo Home Hemo Home Assisted Hemo In Center - Self Frequent Dialysis-In Center Frequent - Home Hemo PD Modalities CAPD CCPD In Center IPD Home IPD Training Modalities Training Home Hemo Training CAPD Training CCPD Training IPD</p>	<p>Where is the patient going to, or coming from? (ENTER PROVIDER NUMBER or NAME and STATE)</p>

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NOTE!!!!

Do not use your Corporate Numbers For this column! If You do not know the Medicare Provider Number, please use Name (if Known) City and State to Identify provider.

Sending/Receiving Facility

Where is the patient going to, or coming from? (ENTER PROVIDER NUMBER or NAME and STATE)

The diagram shows a rectangular box with a thick border. The top border is a thick black line. The text 'Sending/Receiving Facility' is centered at the top. Below it, the instruction 'Where is the patient going to, or coming from? (ENTER PROVIDER NUMBER or NAME and STATE)' is centered. A thin line from the text 'Do not use your Corporate Numbers' above points to the top border of the box. A larger thin line from the right side of the box extends downwards and to the right, ending in a curved shape.