

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MMDDYYYY)	LAST NAME	FIRST NAME	TRANSPLANT TYPE			TRANSPLANT DATE	WAS PT ON CHRONIC DX PRIOR TO TXP** Y/N
				CAD	LRD	LUD		
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COMPLETED BY: _____ DATE: _____ PHONE #: _____

Complete this Transplant Facility Report each month, listing each patient who received a kidney transplant at your facility. **FAX TO NETWORK 13** at 405-942-6181 NO LATER THAN THE TENTH OF EACH MONTH AFTER THE REPORT MONTH.

****MEDICAL EVIDENCE REPORT – CMS 2728**

- (a) This form must be completed within 45 days for all patients who initially receive a kidney transplant instead of a course of dialysis.
- (b) A second (or “Supplemental”) CMS 2728 should be completed for a kidney transplant patient if the transplant occurs during the qualifying period for Medicare entitlement (the first three months after initial start of dialysis therapy) because the ESRD patient may be eligible for earlier Medicare entitlement. If this transplant information was not reported on the initial 2728, then a second 2728 should be completed and marked clearly at the top “SUPPLEMENTAL”.