



# ESRD Medical Evidence Report (CMS-2728) Mandatory Field Checklist

- A. Complete for All ESRD Patients (Check purpose of form)
- Field 1 Name (Last, First, Middle Initial)
- Field 3 Social Security Number
- Field 4 Date of Birth
- Field 5 Full Address (Include City, State, and Zip)
- Field 7 Sex
- Field 8 Ethnicity (Complete Field 9 if Hispanic or Latino)
- Field 10 Race (Check all that apply. Complete Tribe for American Indian or Alaskan Native, complete Field 9 for Native Hawaiian or other Pacific Islander)
- Field 11 Is Patient Applying for ESRD Medicare Coverage
- Field 12 Medical Coverage
- Field 13 Height
- Field 14 Dry Weight
- Field 15 Primary Cause of Renal Failure
- Field 16 Employment Status (Must complete both Prior to ESRD and Current)
- Field 17 Co-Morbid Conditions (Check all that apply or None if patient has no co-morbids)
- Field 18 Prior to ESRD therapy (Must complete all questions. Check Unknown if not known.)
- Field 19b Serum Creatinine value and date (Must be within 45 days PRIOR to first dialysis treatment or transplant)
- Field 20 Name of Provider
- Field 21 Medicare Provider Number
- Field 22 Primary Dialysis Setting
- Field 23 Primary Type of Dialysis (include sessions per week and hours per session for Hemodialysis)
- Field 24 Date Regular Dialysis Began
- Field 25 Date Patient Started Chronic Dialysis at Current Facility
- Field 26 Has patient been informed of kidney transplantation options? (If patient has not been informed, indicate why in Field 27)
- Field 46 Attending Physician
- Field 48 UPIN of Physician
- Field 49 Attending Physician's Signature of Attestation
- Field 50 Date (Date signed by attending physician)
- Field 54 Signature of Patient
- Field 55 Date (Date signed by patient)



# ESRD Death Notification (CMS-2746) Mandatory Field Checklist

- Field 1 Patient's Last Name, First, MI*
- Field 2 Medicare Claim Number (if patient has one)*
- Field 3 Patient's Sex*
- Field 4 Date of Birth*
- Field 5 Social Security Number (if patient has one)*
- Field 6 Patient's State of Residence*
- Field 7 Place of Death*
- Field 8 Date of Death*
- Field 9 Modality at Time of Death*
- Field 10 Provider Name and Address (City and State)*
- Field 11 Provider Number*
- Field 12a Causes of Death – Primary Cause*
- Field 12b Were there secondary causes? (Either No or Yes must be checked. If yes, at least one secondary cause must be specified.)*
- Field 13 Renal replacement therapy discontinued prior to death*
- Field 14 Discontinuation after patient/family request? (Check one)*
- Field 15a Date of most recent transplant (indicate unknown if patient was transplanted at some point but date is unknown)*
- Field 17 Name of Physician*
- Field 18 Signature of Person Completing this Form AND Date (This does not need to be the physician unless that is the policy of your facility)*