



EQRS New User Training

Submit an Initial Form-CMS 2728



**End Stage Renal Disease
Quality Reporting System**



Today's Trainer

ESRD Quality Program Support (QPS)



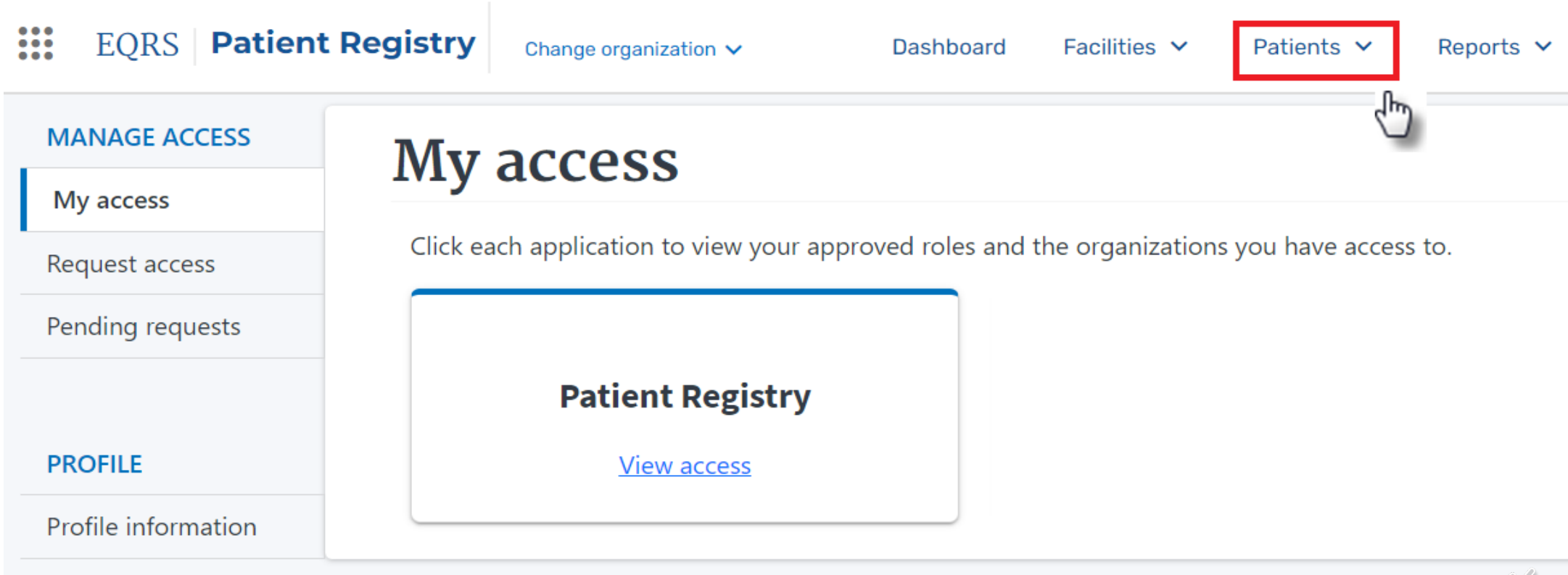
Tricia Phulchand BSN, RN



Submit an Initial Form CMS 2728



Click Patients



The screenshot shows the EQRS Patient Registry interface. At the top, there is a navigation bar with the EQRS logo, the text 'EQRS Patient Registry', and several menu items: 'Change organization', 'Dashboard', 'Facilities', 'Patients', and 'Reports'. The 'Patients' menu item is highlighted with a red rectangular box, and a mouse cursor is pointing at it. Below the navigation bar, there is a sidebar on the left with two main sections: 'MANAGE ACCESS' and 'PROFILE'. Under 'MANAGE ACCESS', there are three items: 'My access', 'Request access', and 'Pending requests'. Under 'PROFILE', there is one item: 'Profile information'. The main content area is titled 'My access' and contains the text: 'Click each application to view your approved roles and the organizations you have access to.' Below this text is a large white box with a blue border containing the text 'Patient Registry' and a blue link 'View access'. In the bottom right corner of the interface, there is a speaker icon.

Click Search Patients



EQRS

Patient Registry

Change organization ▾

Dashboard

Facilities ▾

Patients ▲

Reports ▾

MANAGE ACCESS

My access

Request access

Pending requests

PROFILE

Profile information

My access

Click each application to view your approved roles and the organizations you have access to.

Patient Registry

[View access](#)

Search Patients

Admit a Patient

Manage Clinical

Clinical Depression

Social Drivers of Health
(SDOH) Patient Screening

Action List



Enter Search Criteria

Search Patients

Use the criteria below to search for a patient.

[? Help](#) ▾

SEARCH

Patient criteria

Patient's First Name

Patient's Last Name

Medicare Beneficiary Identifier

Social Security Number

EQRS Patient ID (aka CROWN UPI)

Sex Assigned at Birth, on Your Original Birth Certificate

Criteria

[Clear all](#)

Patient's First Name

✖ ITSA

Patient's Last Name

✖ PATIENT

Submit



Click EQRS Patient ID

Search Patient Results

[Help](#)

[Back to Search](#)

EQRS Patient ID (aka CROWN UPI)	First Name	Middle Initial	Last Name	Gender	Date of Birth	Date of Death	Social Security Number	HICNUM	Medicare Beneficiary Identifier	SIMS UPI
3100008572	Itsa		Patient	F	01/01/1960		XXXXX1234	N/A	N/A	

Page Size

« Prev 1 Next »

Showing 1 to 1 of 1 results

10 ▼



Click Form 2728

MANAGE PATIENT

- Patient
- Patient History
- Admissions
- Treatments
- Infections
- Vaccinations
- Form 2728**



[Collapse All](#)

Patient Information ^

Patient's first name: ITSA	Middle initial:
Patient's last name: PATIENT	Suffix:
Date of birth: 01/01/1960	Gender: F
Social Security Number: XXXXX1234	
Medicare Beneficiary Identifier: N/A	
Medicare Claim Number: N/A	



Click Add Initial 2728

Eligible 2728 Forms	Admit Date	Admit Facility	Due Date	Add 2728
Initial Dialysis	07/08/2024	ABC DIALYSIS	08/22/2024	Add Initial 2728

Existing 2728 Forms	Status	Admit Facility	Due Date	Date Submitted
No Form 2728s exist for this patient.				



CMS 2728 Section A

A. COMPLETE FOR ALL ESRD PATIENTS - 3104062712

*Check One: <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Re-entitlement <input type="checkbox"/> Supplemental		
(1) *Patient's Last Name PATIENT	*First Name ITSA	MI MI
(2) Medicare Number (if available)	(3) Social Security Number XXX-XX-1111	(4) *Date of Birth (mm/dd/yyyy) 03/10/1967
(5) *Patient Mailing Address (Include City, State and Zip) *Address Line 1: 123 PATIENT LANE Address Line 2: *Zip: 08527 *City: Jackson *State: NJ	(6) Phone Number: (including area code)	(7) Alternate Phone Number:



Form CMS-2728 Section A (continued)

(8) *Sex Assigned at Birth, on Your Original Birth Certificate Female		(9) How Do You Currently Describe Yourself Female	
(10) *Ethnicity Not Hispanic or Latino		(11) Country/Area of Origin or Ancestry	
(12) *Race White Name of Enrolled/Principal Tribe:		(13) *Is patient applying for ESRD Medicare coverage? No	
(14) *Current Medical Coverage (Check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> VA <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Employer Group Health Insurance <input checked="" type="checkbox"/> Other <input type="checkbox"/> None		(15) *Height 68 Inches	
		(16) *Dry Weight 165 Pounds	



Form CMS-2728 Section A (continued)

(17) *Primary cause of Renal Failure

(18) *Occupation Status (6 months prior and current status)

Prior:

Current:

Retired Due to Age/Preference

(19) *Co-Morbid Conditions

<input type="checkbox"/> a. Congestive heart failure	<input type="checkbox"/> y. Intestinal Obstruction/Perforation
<input type="checkbox"/> b. Atherosclerotic heart disease ASHD	<input type="checkbox"/> z. Chronic Pancreatitis
<input type="checkbox"/> c. Other cardiac disease	<input type="checkbox"/> aa. Inflammatory Bowel Disease
<input type="checkbox"/> d. Cerebrovascular disease, CVA, TIA*	<input type="checkbox"/> bb. Bone/Joint/Muscle Infections/Necrosis
<input type="checkbox"/> e. Peripheral vascular disease*	<input type="checkbox"/> cc. Dementia
<input type="checkbox"/> f. History of hypertension	<input type="checkbox"/> dd. Major Depressive Disorder
<input type="checkbox"/> g. Amputation	<input type="checkbox"/> ee. Myasthenia Gravis
<input type="checkbox"/> h. Diabetes, currently on insulin	<input type="checkbox"/> ff. Guillain-Barre Syndrome
<input type="checkbox"/> h1. Diabetes, currently use other injectable	<input type="checkbox"/> gg. Inflammatory Neuropathy
<input type="checkbox"/> h2. Diabetes, on oral medications	<input type="checkbox"/> hh. Parkinson's Disease
<input type="checkbox"/> h3. Diabetes, without medications	<input type="checkbox"/> ii. Huntington's Disease
<input type="checkbox"/> i. Diabetic retinopathy	<input type="checkbox"/> jj. Seizure Disorders and Convulsions
<input type="checkbox"/> j. Chronic obstructive pulmonary disease	<input type="checkbox"/> kk. Interstitial lung disease
<input type="checkbox"/> k. Tobacco use (current smoker)	<input type="checkbox"/> ll. Partial-thickness Dermis Wounds
<input type="checkbox"/> l. Malignant neoplasm, Cancer	<input type="checkbox"/> mm. Complications of specified implanted device or graft
<input type="checkbox"/> m. Toxic nephropathy	<input type="checkbox"/> nn. Artificial Openings for feeding or Elimination
<input type="checkbox"/> n. Alcohol dependence	Consider for Pediatric Patients
<input type="checkbox"/> o. Drug dependence*	<input type="checkbox"/> oo. Chronic lung disease (including dependency on CPAP and ventilators)
<input type="checkbox"/> p. Inability to ambulate	<input type="checkbox"/> pp. Vision impairment
<input type="checkbox"/> q. Inability to transfer	<input type="checkbox"/> qq. Feeding tube dependence
<input type="checkbox"/> r. Needs assistance with daily activities	<input type="checkbox"/> rr. Failure to thrive/feeding disorders
<input type="checkbox"/> s. Alternate housing arrangement - Assisted Living	<input type="checkbox"/> ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
<input type="checkbox"/> s1. Alternate housing arrangement - Nursing Home	<input type="checkbox"/> tt. Congenital bladder/urinary tract anomalies
<input type="checkbox"/> s2. Alternate housing arrangement - Other Institution	<input type="checkbox"/> uu. Non-kidney solid organ
<input type="checkbox"/> t. Non-renal congenital abnormality	<input type="checkbox"/> vv. Stem cell transplant
<input type="checkbox"/> u. None	<input type="checkbox"/> ww. Neurocognitive impairment
<input type="checkbox"/> v. Protein Calorie Malnutrition	<input type="checkbox"/> xx. Global developmental delay
<input type="checkbox"/> w. Morbid Obesity	<input type="checkbox"/> yy. Cerebral palsy
<input type="checkbox"/> x. Endocrine Metabolic Disorders	<input type="checkbox"/> zz. Seizure disorder



Form CMS-2728 Section A (continued)

(20) *Prior to ESRD therapy:

a. Did patient receive exogenous erythropoietin or equivalent? If Yes, answer:

b. Was patient under care of nephrologist? If Yes, answer:

c. Was patient under care of kidney dietitian? If Yes, answer:

d. What access was used on first outpatient dialysis:
AVF
Graft
PD Catheter
Central Venous Catheter
Other

If not AVF, then:

a. Is maturing AVF present?

b. Is maturing graft present?

Was one lumen of the Central Venous Catheter used and one needle placed in a AVF or graft?

Is PD catheter present?

e. Was patient diagnosed with an acute kidney injury in the last 12 months?

If Yes, was dialysis required?

f. Does the patient indicate they received and understood options for a home dialysis modality?

g. Does the patient indicate they received and understood options

For a kidney transplant?

For Living donor transplant?

h. Does the patient indicate they received and understood the option of not starting dialysis at all, also called active medical management without dialysis?



Form CMS-2728 Section A (continued)

(21) *Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. If not available within 30 days of admission to the dialysis facility for ESRD treatment, admission laboratory values may be used. (HbA1c and LDL within 1 Year of Most Recent ESRD Episode).

Admission Lab Values

Prior Lab Values

Laboratory Test	Value	Date		
		Month	Day	Year
a. Serum Albumin (g/dl)	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
b. Serum Albumin Lower Limit	<input type="text"/>			
c. Lab Method Used (BCG or BCP)	<input type="text" value="v"/>			
d. *Serum Creatinine (mg/dl)	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
e. Hemoglobin (g/dl)	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
f. HbA1c	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
g. LDL	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
h. Cystatin C	<input type="text"/>	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>



Section A. Laboratory Values – Prior lab values vs. Admission lab values

- Prior Lab Values
 - Laboratory values obtained within 45 days prior to date regular chronic dialysis began (#34).
- Admission Lab Values
 - Laboratory values drawn within 15 days prior to or 15 days after the Date Patient Started Chronic Dialysis at Current Facility (#35).
 - Please note that EQRS will display a warning if the lab date entered is outside of this range.



Form CMS-2728 Section A (continued)

<p>(22) Does the patient have living will or Medical/Physician order for life sustaining treatment?</p> <input type="text"/>
<p>(23) Are you currently concerned about where you will live over the next 90 days?</p> <input type="text"/>
<p>(24)</p> <p>a. Do you have caregiver support to assist with your daily care? <input type="text"/></p> <p>b. Do you have caregiver support to assist with home dialysis/kidney transplant? <input type="text"/></p> <p>c. Does the caregiver live with you? <input type="text"/></p>
<p>(25) Do you have access to reliable transportation?</p> <input type="text"/>
<p>(26a) Do you understand health literature in English?</p> <input type="text"/>
<p>(26b) Do you need a different way other than written documents to learn about your health?</p> <input type="text"/>
<p>(26c) Do you need a translator to understand health information?</p> <input type="text"/>
<p>(27) Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating?</p> <input type="text"/>
<p>(28) Within the past 12 months, has the food you bought not lasted and you didn't have money to get more?</p> <input type="text"/>
<p>(29) Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months?</p> <input type="text"/>



Form CMS-2728 Section A (continued)

New Questions - **OPTIONAL**

22. Does the patient have living will or medical/physician order for life sustaining treatment?

23. Are you currently concerned about where you will live over the next 90 days? (No longer applicable)

24. (a) Do you have caregiver support to assist with your daily care?

(b) With home dialysis/kidney transplant?

(c) Does the caregiver live with you?

25. Do you have access to reliable transportation? (No longer applicable)

26. (a) Do you understand health literature in English?

(b) Do you need a different way other than written documents to learn about your health?

(c) Do you need a translator to understand health information?

27. Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating? (No longer applicable)

28. Within the past 12 months, has the food you bought not lasted and you didn't have money to get more? (No longer applicable)

29. Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months? (No longer applicable)

Click on desired section

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT



C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS



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



E. PHYSICIAN IDENTIFICATION



F. OBTAIN SIGNATURE FROM PATIENT



Save

Submit

Cancel



Form CMS-2728 Section B

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT		
(30) Name of Dialysis Facility ABC DIALYSIS	(31a) CMS Certification Number (CCN) (for item 30)	(31b) Facility NPI (for item 30)
(32) *Primary Dialysis Setting Dialysis Facility/Center		(33) *Primary Type of Dialysis Hemodialysis Sessions Per Week: 3 / Hours Per Session: 4
(34) *Date Regular Chronic Dialysis Began Month Day Year MM DD YYYY	(35) *Date Patient Started Chronic Dialysis at Current Facility 07/08/2024	
(36) *Does the patient understand kidney transplant options at the time of admission? ▼	(37) If patient NOT informed of transplant options (or does not understand transplant options) please check all that apply: <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Patient declined information <input type="checkbox"/> Patient found information overwhelming <input type="checkbox"/> Patient has an absolute contraindication <input type="checkbox"/> Patient has not been assessed at this time <input type="checkbox"/> Other	
(38) *Has the patient been connected to a transplant center with a referral? ▼	(38a) Date of referral (mm/dd/yyyy) Month Day Year MM DD YYYY	
(38b) Name of transplant center Find Facility by facility ID, facility name, facility DBA, facility CCN, facility NPI, phone number, fax number <input type="checkbox"/> Manually enter name Name of transplant center	(38c) CMS Certification Number (CCN) (for item 38b)	(38d) NPI of transplant center (for item 38b)
(39) *Does the patient understand home dialysis options at the time of admission? ▼	(40) If patient NOT informed of home dialysis options (or does not understand home dialysis options) please check all that apply: <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Patient declined information <input type="checkbox"/> Patient found information overwhelming <input type="checkbox"/> Patient has an absolute contraindication <input type="checkbox"/> Patient has not been assessed at this time <input type="checkbox"/> Other	



Form CMS-2728 Section C

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS	
(41) *Date of Transplant (mm/dd/yyyy)	(42) Name of Transplant Hospital
(43a) CMS Certification Number (CCN) (for Item 42)	(43b) Facility NPI for Item 42
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.	
(44) Enter Date (mm/dd/yyyy)	(45) Name of Preparation Hospital
(46a) CMS Certification Number (CCN) (for Item 45)	(46b) Facility NPI for Item 45
(47) *Current Status of Transplant (if Functioning, skip items 49 and 50)	(48) *Type of Transplant
(49) If Non-Functioning, Date of Return to Regular Dialysis	(50) Current Dialysis Setting



Form CMS-2728 Section D

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)			
(51) Name of Training Provider Find Facility by facility ID, facility name, facility DBA, facility CCN, facility NPI, phone number, fax number <input type="text"/>		(52a) CMS Certification Number (CCN) of Training Provider (for Item 51)	(52b) NPI of Training Provider (for Item 51)
(53) Date Training Began (mm/dd/yyyy) Month: <input type="text" value="MM"/> Day: <input type="text" value="DD"/> Year: <input type="text" value="YYYY"/>		(54) Type of Training <input type="text" value="v"/> <input type="text" value="v"/>	
(55) This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis <input type="text" value="v"/>		(56) Date When Patient Completed, or is Expected to Complete, Training Month: <input type="text" value="MM"/> Day: <input type="text" value="DD"/> Year: <input type="text" value="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>			
(57) Printed Name and Signature of Physician personally familiar with the patient's training <input type="text"/>	Month: <input type="text" value="MM"/> Day: <input type="text" value="DD"/> Year: <input type="text" value="YYYY"/>	(58a) UPIN of Physician in Item 57	(58b) NPI of Physician in Item 57

Form CMS-2728 Section E

E. PHYSICIAN IDENTIFICATION		
(59) *Attending Physician NICK FURY		(60) Physician's Phone No.
(61) NPI of Physician in item 59		
PHYSICIAN ATTESTATION		
<p><i>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.</i></p>		
(63) *Date		
Month MM	Day DD	Year YYYY
(66) Remarks		
<div style="border: 1px solid gray; height: 80px;"></div>		

Select the GFR Calculation Method

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.

(68)*Date

Month Day Year

*** Patient unable to sign/mark reason:**

Form Entered Date:	Network: 16
GFR Calculation Method: <input type="text" value="MDRD IDMS standardized"/>	GFR:

Save **Submit** **Cancel**


Patient Unable to Sign Reasons

Patient Unable to Sign Reason	Circumstances for selecting an option
*Lost to follow-up	Select this option AFTER several attempts to reach the patient have been made without success. These include but are not limited to: <ul style="list-style-type: none">• Calling the patient's home and cell phone.• Calling the patient's next of kin or alternate emergency contacts.• Sending certified letter to the patient's home.• Requesting a well-visit from local police department.• Checking local hospitals.
Moved out of the United States and territories	Select this option if the patient has left the country, this may occur in cases when patients from other countries visit short term and then return to their homelands. (Yes, you are responsible for completing Form CMS-2728s on foreign visitors – if no other 2728 form exists for those visitors).
Expired date	Select this option if the patient has passed away before signing the form. Please note that you will need to enter the patient's Date of Death on the form.

*** Please consult your local ESRD Network before selecting Lost to follow-up**

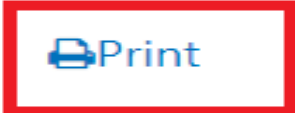
Select Print

- EQRS displays “**Successfully saved form 2728**” message.
- Click the **Print** link.



Successful
Successfully saved form 2728.

View ESRD Medical Evidence (2728) - Saved
ITSA PATIENT (UPI: 3104062712)



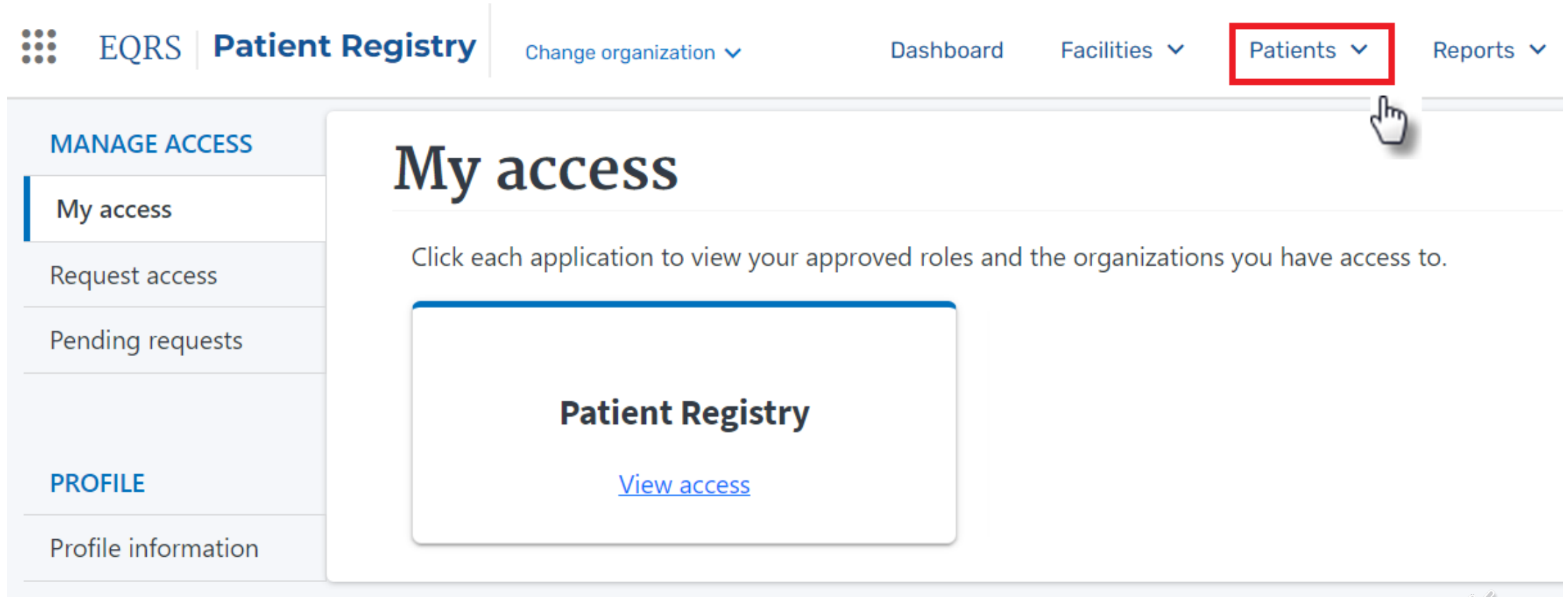
Submit Date:

A. COMPLETE FOR ALL ESRD PATIENTS - 3104062712

FormType: Initial Dialysis	
(1) Patient's Last Name PATIENT	First Name ITSA
(2) Medicare Number (if available)	(3) Social Security Number



Click Patients



The screenshot shows the EQRS Patient Registry interface. The top navigation bar includes a logo, 'EQRS | Patient Registry', and several menu items: 'Change organization', 'Dashboard', 'Facilities', 'Patients', and 'Reports'. The 'Patients' menu item is highlighted with a red box and a hand cursor. Below the navigation bar, the left sidebar contains 'MANAGE ACCESS' (with sub-items 'My access', 'Request access', and 'Pending requests') and 'PROFILE' (with 'Profile information'). The main content area is titled 'My access' and contains the text 'Click each application to view your approved roles and the organizations you have access to.' Below this text is a card for 'Patient Registry' with a 'View access' link. A speaker icon is visible in the bottom right corner of the interface.

EQRS | Patient Registry

Change organization ▾ Dashboard Facilities ▾ Patients ▾ Reports ▾

MANAGE ACCESS

- My access
- Request access
- Pending requests

PROFILE

- Profile information

My access

Click each application to view your approved roles and the organizations you have access to.

Patient Registry

[View access](#)

Click Search Patients



EQRS

Patient Registry

Change organization ▾

Dashboard

Facilities ▾

Patients ▲

Reports ▾

MANAGE ACCESS

My access

Request access

Pending requests

PROFILE

Profile information

My access

Click each application to view your approved roles and the organizations you have access to.

Patient Registry

[View access](#)

Search Patients

Admit a Patient

Manage Clinical

Clinical Depression

Social Drivers of Health
(SDOH) Patient Screening

Action List



Enter Search Criteria

Search Patients

Use the criteria below to search for a patient.

[? Help](#) ▾

SEARCH

Patient criteria

Patient's First Name

Patient's Last Name

Medicare Beneficiary Identifier

Social Security Number

EQRS Patient ID (aka CROWN UPI)

Sex Assigned at Birth, on Your Original Birth Certificate

Criteria

[Clear all](#)

Patient's First Name

✖ ITSA

Patient's Last Name

✖ PATIENT

Submit



Click EQRS Patient ID

Search Patient Results

[? Help](#)

[Back to Search](#)

EQRS Patient ID (aka CROWN UPI)	First Name	Middle Initial	Last Name	Gender	Date of Birth	Date of Death	Social Security Number	HICNUM	Medicare Beneficiary Identifier	SIMS UPI
3100008572	Itsa		Patient	F	01/01/1960		X000X1234	N/A	N/A	

Showing 1 to 1 of 1 results

Page Size

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« Prev 1 Next »



Click Form 2728

MANAGE PATIENT

- Patient
- Patient History
- Admissions
- Treatments
- Infections
- Vaccinations
- Form 2728**



Collapse All

Patient Information ^

Patient's first name: ITSA	Middle initial:
Patient's last name: PATIENT	Suffix:
Date of birth: 01/01/1960	Gender: F
Social Security Number: XXXXX1234	
Medicare Beneficiary Identifier: N/A	
Medicare Claim Number: N/A	



Click Initial Dialysis

MANAGE PATIENT

Manage Form 2728 (ITSA PATIENT - 3100114041)

Patient

Patient History

Admissions

Treatments

Infections

Vaccinations

Form 2728

Eligible 2728 Forms

Admit Date

Admit Facility

Due Date

Add 2728

No Form 2728 is required for this patient.

Existing 2728 Forms

Status

Admit Facility

Due Date

Date Submitted

[Initial Dialysis](#) +

Saved

ABC Dialysis

08/22/2024



Click Edit

View ESRD Medical Evidence (2728) - Saved

 Print

 Edit

 Delete

 Help ▾

Submit Date:

OMB CONTROL NUMBER 0938-0046 Expires 2026-11-30

A. COMPLETE FOR ALL ESRD PATIENTS - 3104062712

FormType: Initial Dialysis		
(1) Patient's Last Name PATIENT	First Name ITSA	MI
(2) Medicare Number (if available)	(3) Social Security Number XXX-XX-1111	(4) Date of Birth (mm/dd/yyyy) 03/10/1967
(5) Patient Mailing Address (Include City, State and Zip) 123 PATIENT LANE	(6) Phone Number (including area code)	(7) Alternate Phone Number



Section E

- Scroll down to Section E.
- Enter the date the physician signed the form.

E. PHYSICIAN IDENTIFICATION		
(59) *Attending Physician	(60) Physician's Phone No.	
<input type="text" value="NICK FURY"/>		
(61) NPI of physician in item 59		
PHYSICIAN ATTESTATION		
<i>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.</i>		
(63) *Date		
Month	Day	Year
<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>
(66) Remarks		
<input type="text"/>		

Section F

- Scroll to Section F.
- Enter the date the patient signed the form and click **Submit**.

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.

(68)*Date

Month Day Year

*** Patient unable to sign/mark reason:**

Form Entered Date: 08/15/2024	Network: 16
GFR Calculation Method: <input type="text" value="MDRD IDMS standardized"/>	GFR: 0.0



[Save](#) [Submit](#) [Cancel](#)

Successful Submission

EQRS displays the “**Successfully submitted form 2728**” message.

 **Successful**
Successfully submitted form 2728.

View ESRD Medical Evidence (2728) - Submitted

 Print

 Help ▾

Submit Date: 08/10/2024

OMB CONTROL NUMBER 0938-0046 Expires 2026-11-30

A. COMPLETE FOR ALL ESRD PATIENTS - 3104062712

FormType: Initial Dialysis		
(1) Patient's Last Name PATIENT	First Name ITSA	MI
(2) Medicare Number (if available)	(3) Social Security Number XXX-XX-1111	(4) Date of Birth (mm/dd/yyyy) 03/10/1967
(5) Patient Mailing Address (Include City, State and Zip) 123 PATIENT LANE	(6) Phone Number (including area code)	(7) Alternate Phone Number

