EQRS New User Training
Submit an Initial Form-CMS 2728

End Stage Renal Disease Quality Reporting System

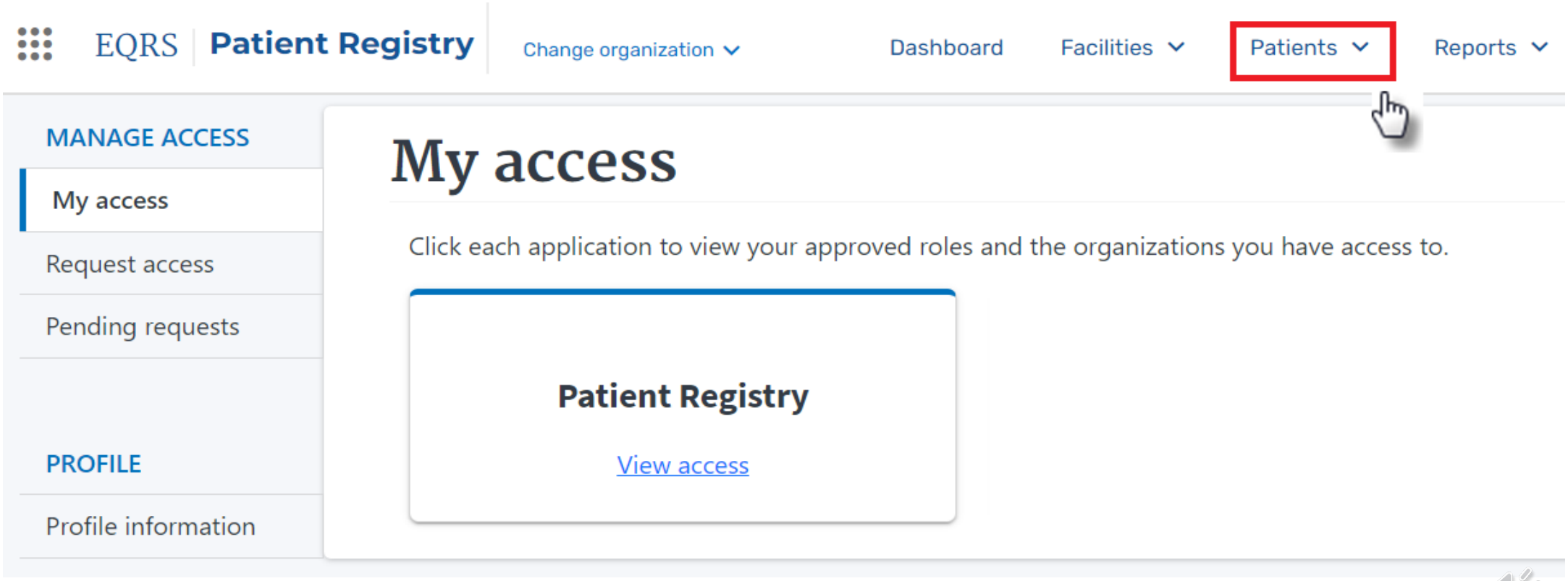
Today’s Trainer

ESRD Quality Program Support (QPS)

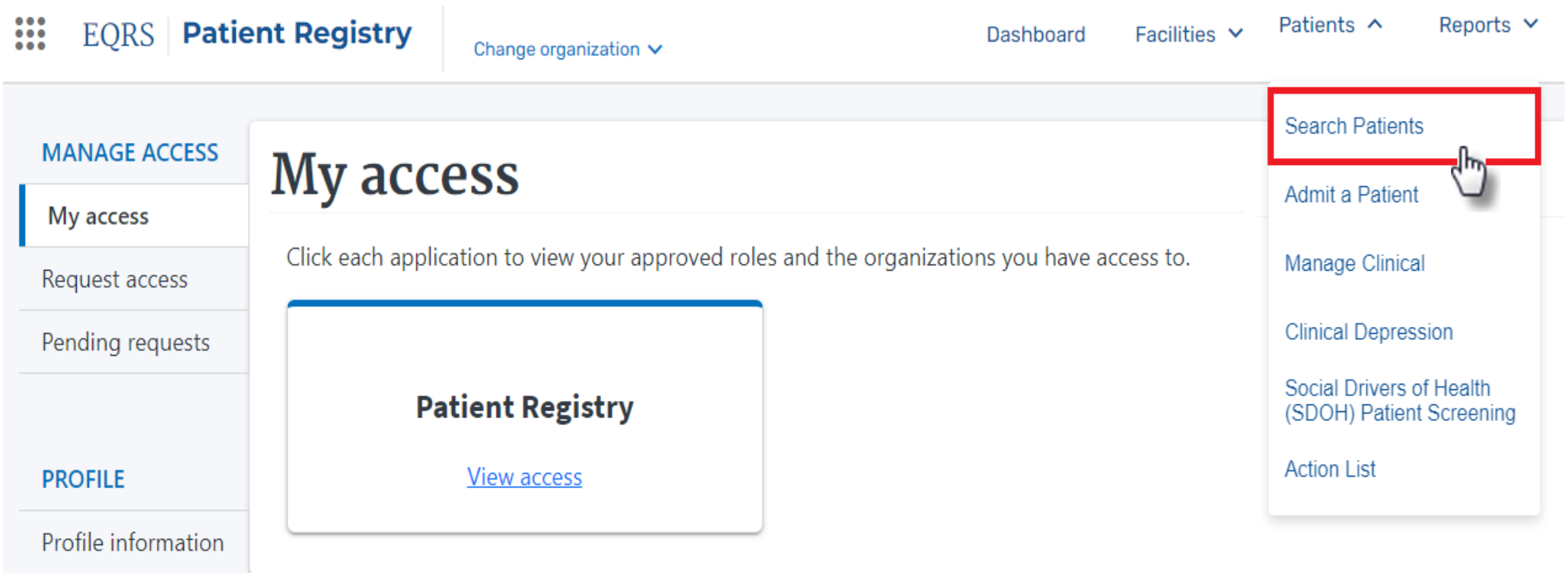
Tricia Phulchand BSN, RN

Submit an Initial Form CMS 2728

Click Patients



Click Search Patients



Enter Search Criteria

Search Patients

Use the criteria below to search for a patient.

Help

SEARCH

Patient criteria

Patient's First Name: ITSA

Patient's Last Name: PATIENT

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

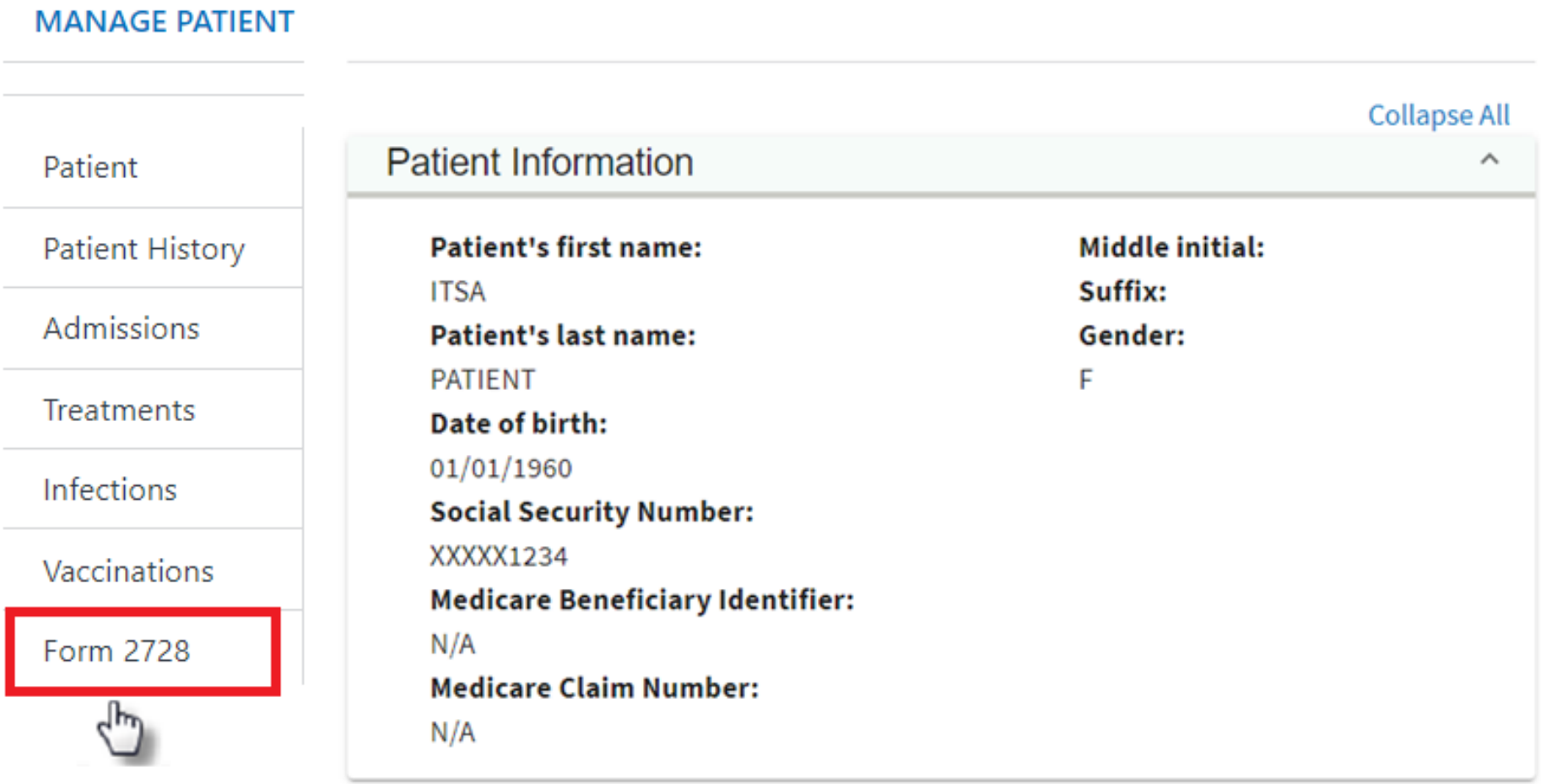
Patient's Last Name

PATIENT

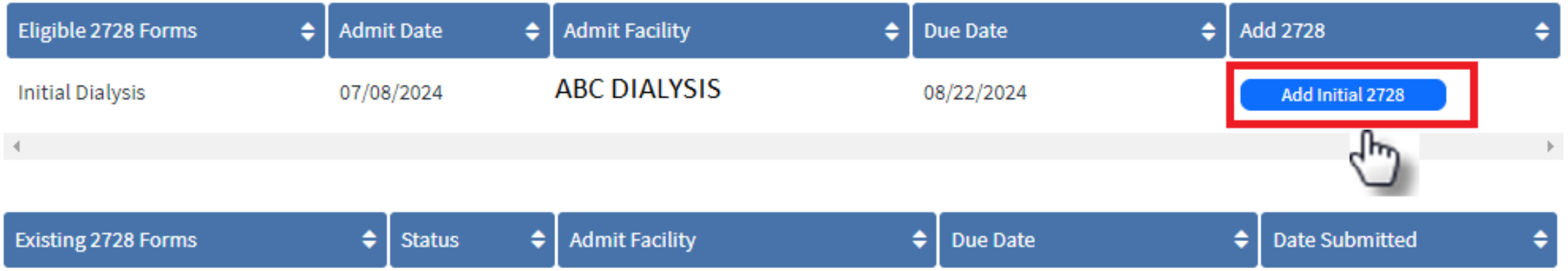
Submit

Click EQRS Patient ID

Click Form 2728



Click Add Initial 2728



CMS 2728 Section A

A. COMPLETE FOR ALL ESRD PATIENTS - 3104062712

*Check One:

☑ Initial ☐ Re-entitlement ☐ Supplemental

(1) *Patient's Last Name	*First Name	MI
PATIENT	ITSA	

(2) Medicare Number (if available)	(3) Social Security Number	(4) *Date of Birth (mm/dd/yyyy)
	XXX-XX-1111	03/10/1967

(5) *Patient Mailing Address (Include City, State and Zip)	(6) Phone Number: (including area code)	(7) Alternate Phone Number:
*Address Line 1: 123 PATIENT LANE Address Line 2: *Zip: 08527 *City: Jackson *State: NJ		

Form CMS-2728 Section A (continued)

(8) *Sex Assigned at Birth, on Your Original Birth Certificate	(9) How Do You Currently Describe Yourself
Female	Female

(10) *Ethnicity	(11) Country/Area of Origin or Ancestry
Not Hispanic or Latino	

(12) *Race	(13) *Is patient applying for ESRD Medicare coverage?
White **Name of Enrolled/Principal Tribe:**	No

(14) *Current Medical Coverage *(Check all that apply)*

- [ ] Medicaid
- [ ] VA
- [ ] Medicare
- [ ] Medicare Advantage
- [ ] Employer Group Health Insurance
- [x] Other
- [ ] 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

- [ ] a. Congestive heart failure
- [ ] b. Atherosclerotic heart disease ASHD
- [ ] c. Other cardiac disease
- [ ] d. Cerebrovascular disease, CVA, TIA*
- [ ] e. Peripheral vascular disease*
- [ ] f. History of hypertension
- [ ] g. Amputation
- [ ] h. Diabetes, currently on insulin
- [ ] h1. Diabetes, currently use other injectable
- [ ] h2. Diabetes, on oral medications
- [ ] h3. Diabetes, without medications
- [ ] i. Diabetic retinopathy
- [ ] j. Chronic obstructive pulmonary disease
- [ ] k. Tobacco use (current smoker)
- [ ] l. Malignant neoplasm, Cancer
- [ ] m. Toxic nephropathy
- [ ] n. Alcohol dependence
- [ ] o. Drug dependence*
- [ ] p. Inability to ambulate
- [ ] q. Inability to transfer
- [ ] r. Needs assistance with daily activities
- [ ] s. Alternate housing arrangement - Assisted Living
- [ ] s1. Alternate housing arrangement - Nursing Home
- [ ] s2. Alternate housing arrangement - Other Institution
- [ ] t. Non-renal congenital abnormality
- [ ] u. None
- [ ] v. Protein Calorie Malnutrition
- [ ] w. Morbid Obesity
- [ ] x. Endocrine Metabolic Disorders
- [ ] y. Intestinal Obstruction/Perforation
- [ ] z. Chronic Pancreatitis
- [ ] aa. Inflammatory Bowel Disease
- [ ] bb. Bone/Joint/Muscle Infections/Necrosis
- [ ] cc. Dementia
- [ ] dd. Major Depressive Disorder
- [ ] ee. Myasthenia Gravis
- [ ] ff. Guillain-Barre Syndrome
- [ ] gg. Inflammatory Neuropathy
- [ ] hh. Parkinson's Disease
- [ ] ii. Huntington's Disease
- [ ] jj. Seizure Disorders and Convulsions
- [ ] kk. Interstitial lung disease
- [ ] ll. Partial-thickness Dermis Wounds
- [ ] mm. Complications of specified implanted device or graft
- [ ] nn. Artificial Openings for feeding or Elimination

Consider for Pediatric Patients

- [ ] oo. Chronic lung disease (including dependency on CPAP and ventilators)
- [ ] pp. Vision impairment
- [ ] qq. Feeding tube dependence
- [ ] rr. Failure to thrive/feeding disorders
- [ ] ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
- [ ] tt. Congenital bladder/urinary tract anomalies
- [ ] uu. Non-kidney solid organ
- [ ] vv. Stem cell transplant
- [ ] ww. Neurocognitive impairment
- [ ] xx. Global developmental delay
- [ ] yy. Cerebral palsy
- [ ] zz. Seizure disorder

Form CMS-2728 Section A (continued)

(20) *Prior to ESRD therapy:

a. Did patient receive exogenous erythropoietin or equivalent? No — If Yes, answer:

b. Was patient under care of nephrologist? No — If Yes, answer:

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

- <6 months
- 6 - 12 months
- >12 months

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? Yes

b. Is maturing graft present? No

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? No

If Yes, was dialysis required?

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

g. Does the patient indicate they received and understood options

For a kidney transplant? Yes

For Living donor transplant? Yes

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

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
a. Serum Albumin (g/dl)		Month MM Day DD Year YYYY
b. Serum Albumin Lower Limit		
c. Lab Method Used (BCG or BCP)		
d. *Serum Creatinine (mg/dl)		Month MM Day DD Year YYYY
e. Hemoglobin (g/dl)		Month MM Day DD Year YYYY
f. HbA1c		Month MM Day DD Year YYYY
g. LDL		Month MM Day DD Year YYYY
h. Cystatin C		Month MM Day DD Year 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)

(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?

(24)

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

b. Do you have caregiver support to assist with home dialysis/kidney transplant?

c. Does the caregiver live with you?

(25) Do you have access to reliable transportation?

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

(26b) Do you need a different way other than written documents to learn about your health?

(26c) 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?

(28) Within the past 12 months, has the food you bought not lasted and you didn't have money to get more?

(29) Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months?

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: MM Day: DD Year: 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:** ☐ Cognitive Impairment ☐ Patient declined information ☐ Patient found information overwhelming ☐ Patient has an absolute contraindication ☐ Patient has not been assessed at this time ☐ Other
(38) *Has the patient been connected to a transplant center with a referral?		**(38a) Date of referral (mm/dd/yyyy)** Month: MM Day: DD Year: YYYY
(38b) Name of transplant center Find Facility by facility ID, facility name, facility DBA, facility CCN, facility NPI, phone number, fax number ☐ 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:** ☐ Cognitive Impairment ☐ Patient declined information ☐ Patient found information overwhelming ☐ Patient has an absolute contraindication ☐ Patient has not been assessed at this time ☐ 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

(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: MM | Day: DD | Year: YYYY

(54)Type of Training

(55) This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis

(56) Date When Patient Completed, or is Expected to Complete, Training
Month: MM | Day: DD | Year: YYYY

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.

(57) Printed Name and Signature of Physician personally familiar with the patient's training
Month: MM | Day: DD | Year: 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

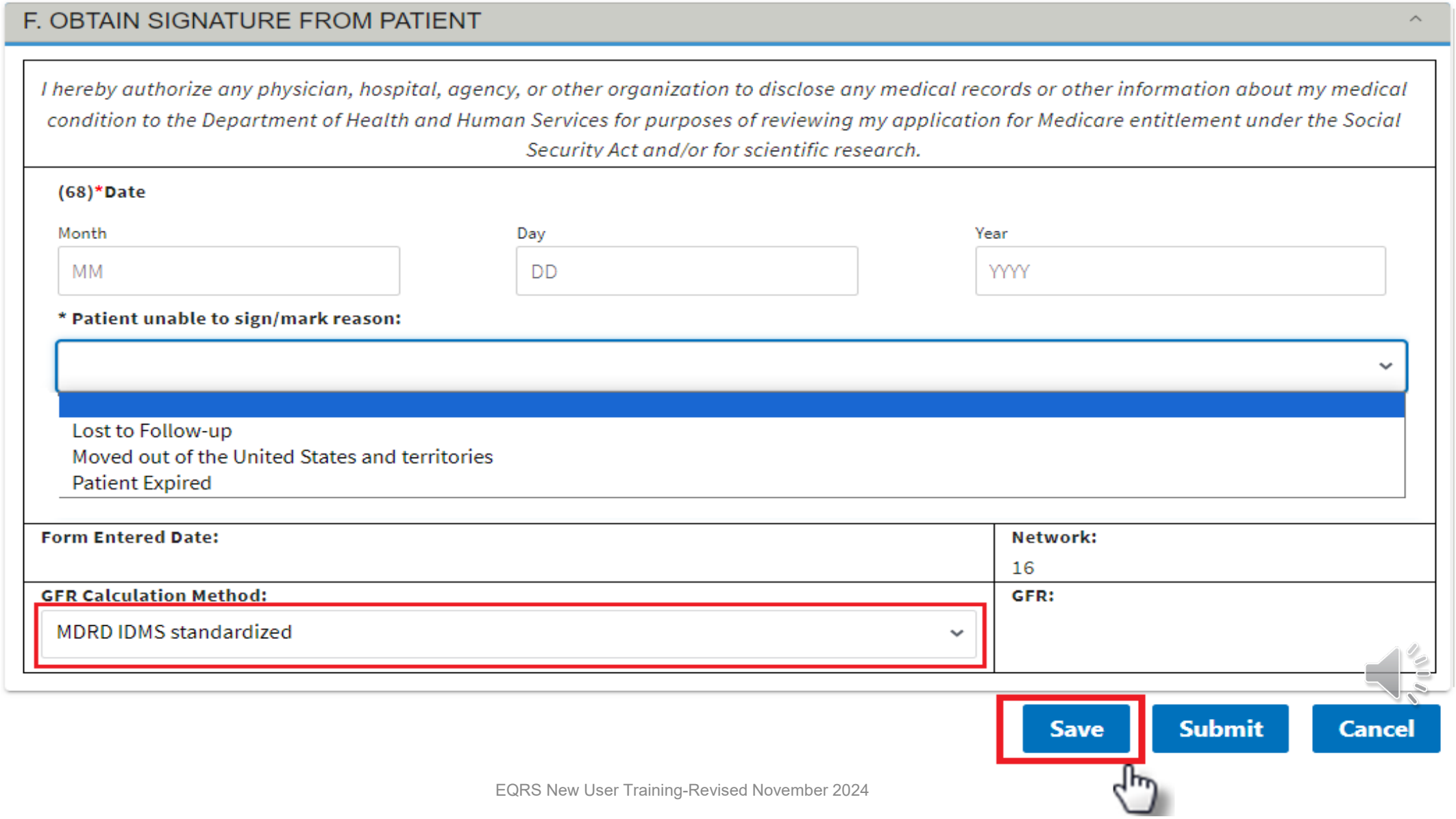
I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires 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.

(63) *Date

Month: MM | Day: DD | Year: YYYY

(66) Remarks

Select the GFR Calculation Method



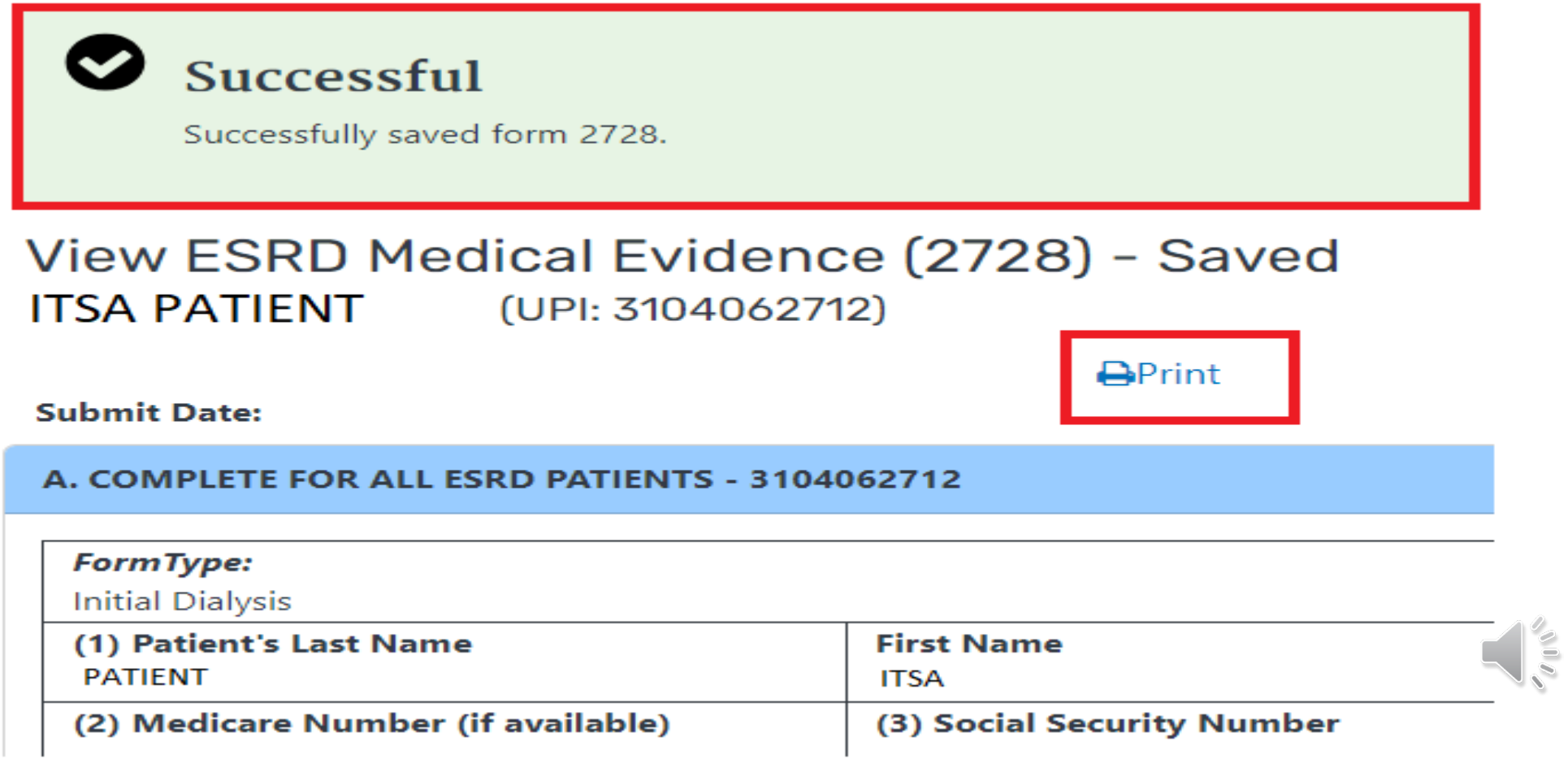
Patient Unable to Sign Reasons

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: • 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.

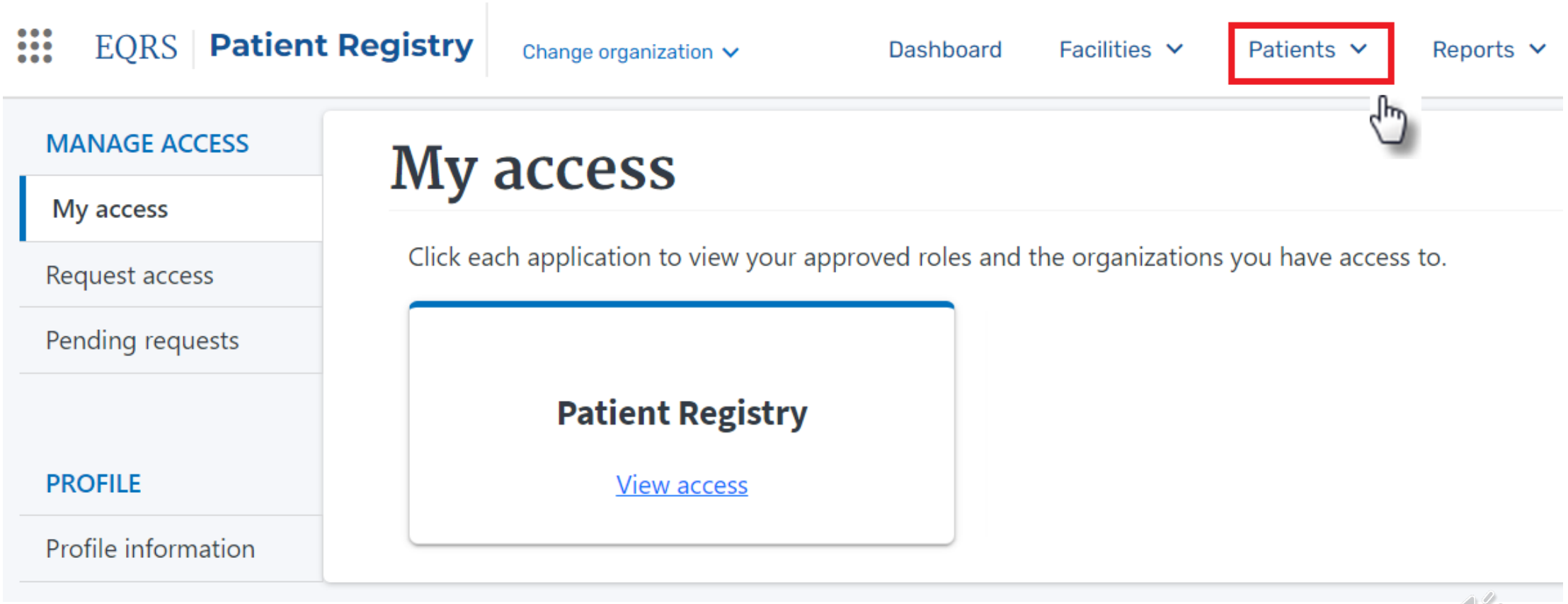
*** Please consult your local ESRD Network before selecting Lost to follow-up**

Select Print

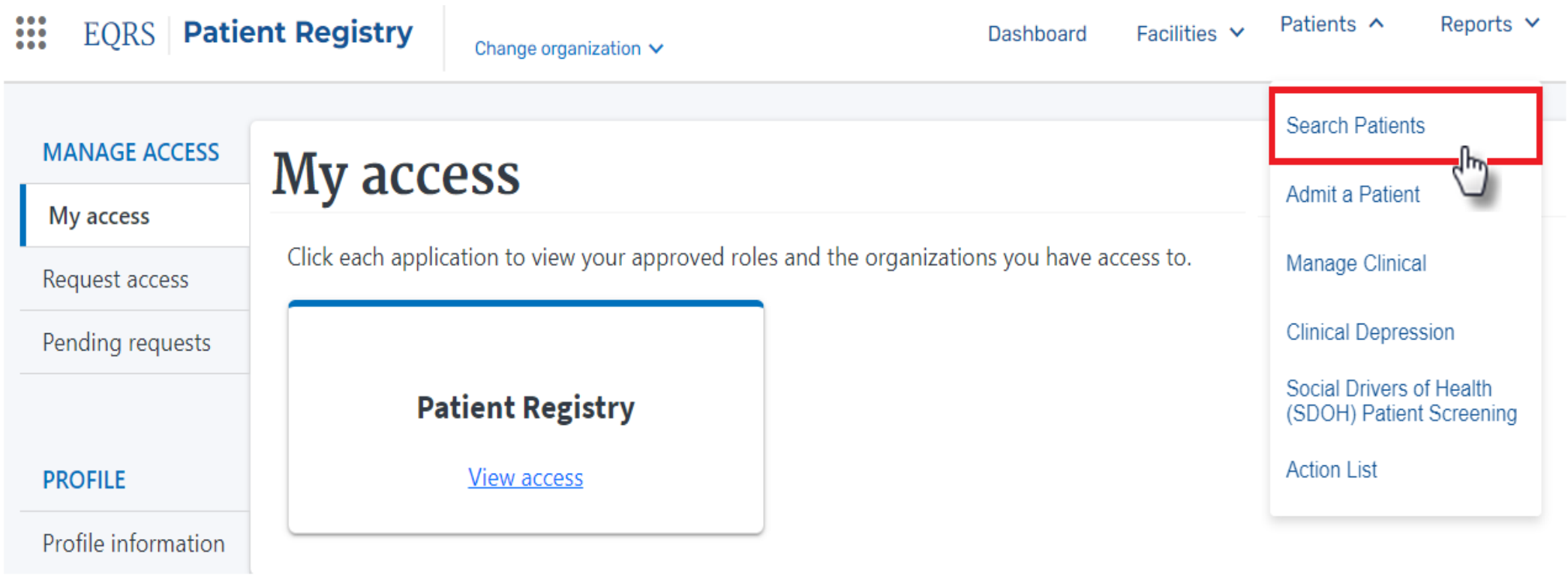
- EQRS displays “**Successfully saved form 2728**” message.
- Click the **Print** link.



Click Patients



Click Search Patients



Enter Search Criteria

Search Patients

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Help

SEARCH

Patient criteria

Patient's First Name: ITSA

Patient's Last Name: PATIENT

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

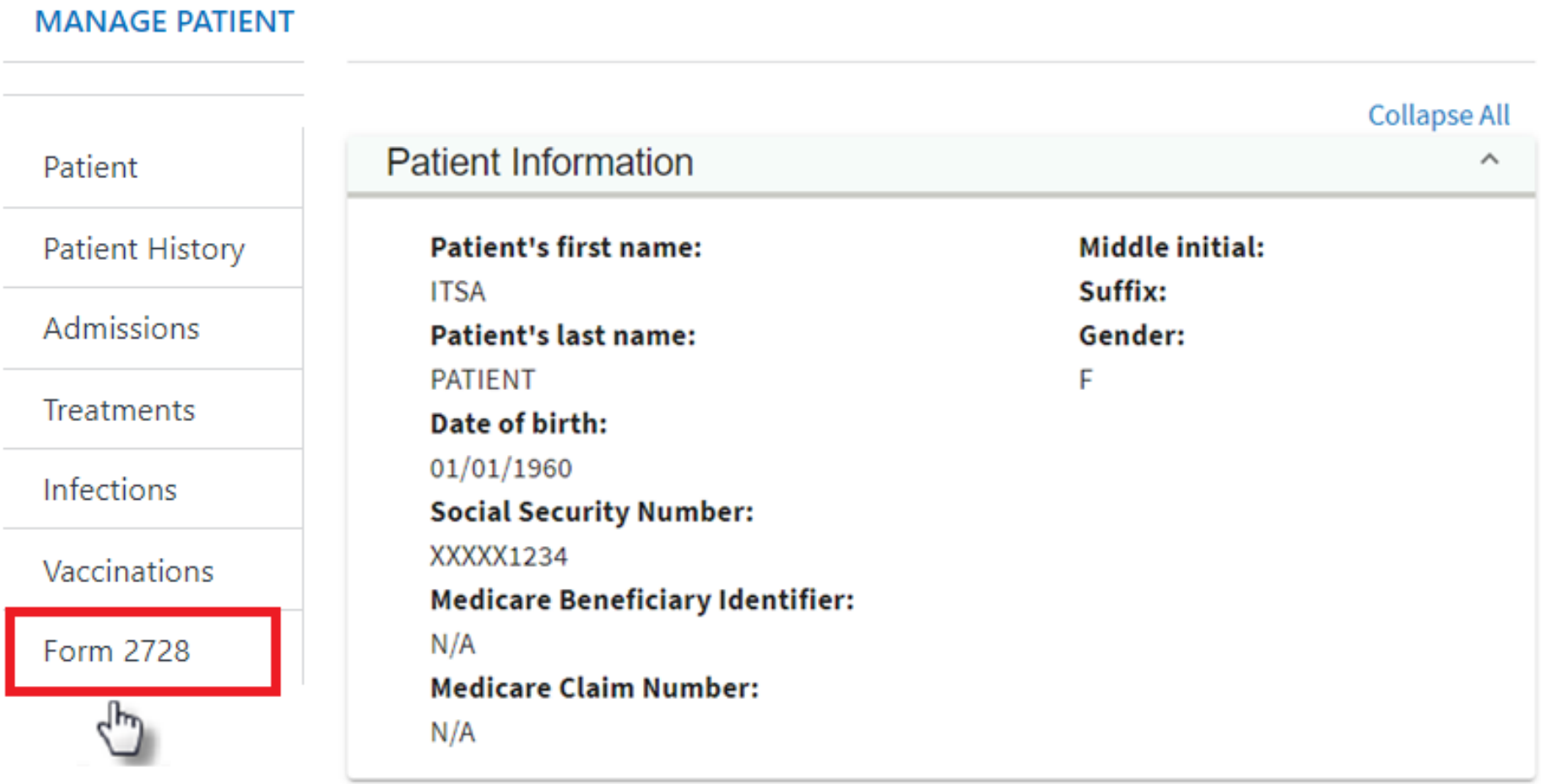
Patient's Last Name

PATIENT

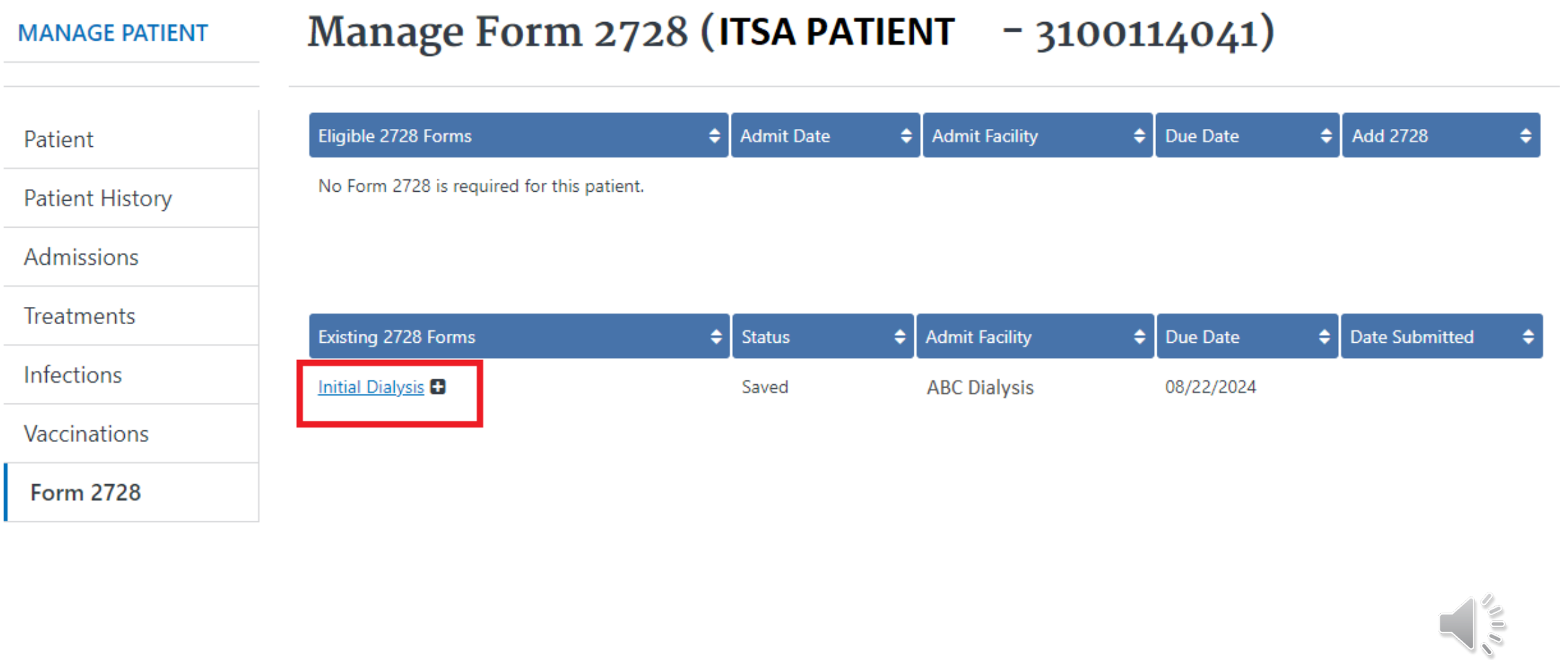
Submit

Click EQRS Patient ID

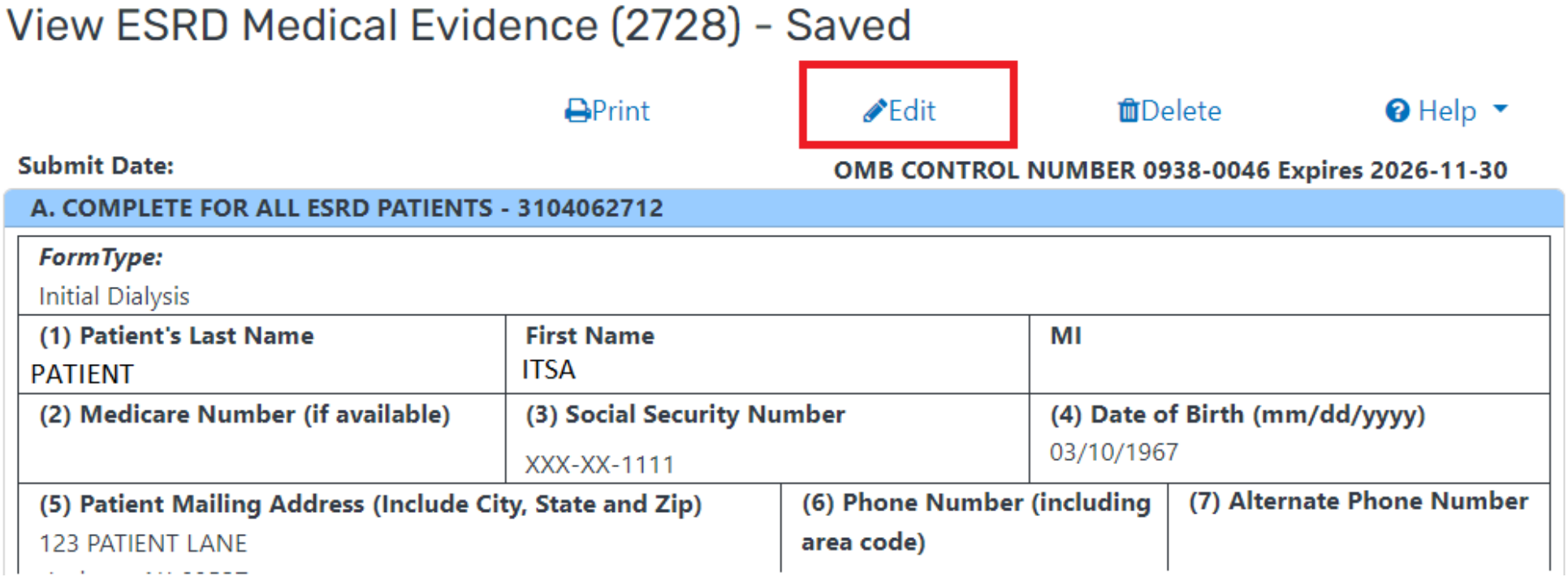
Click Form 2728



Click Initial Dialysis

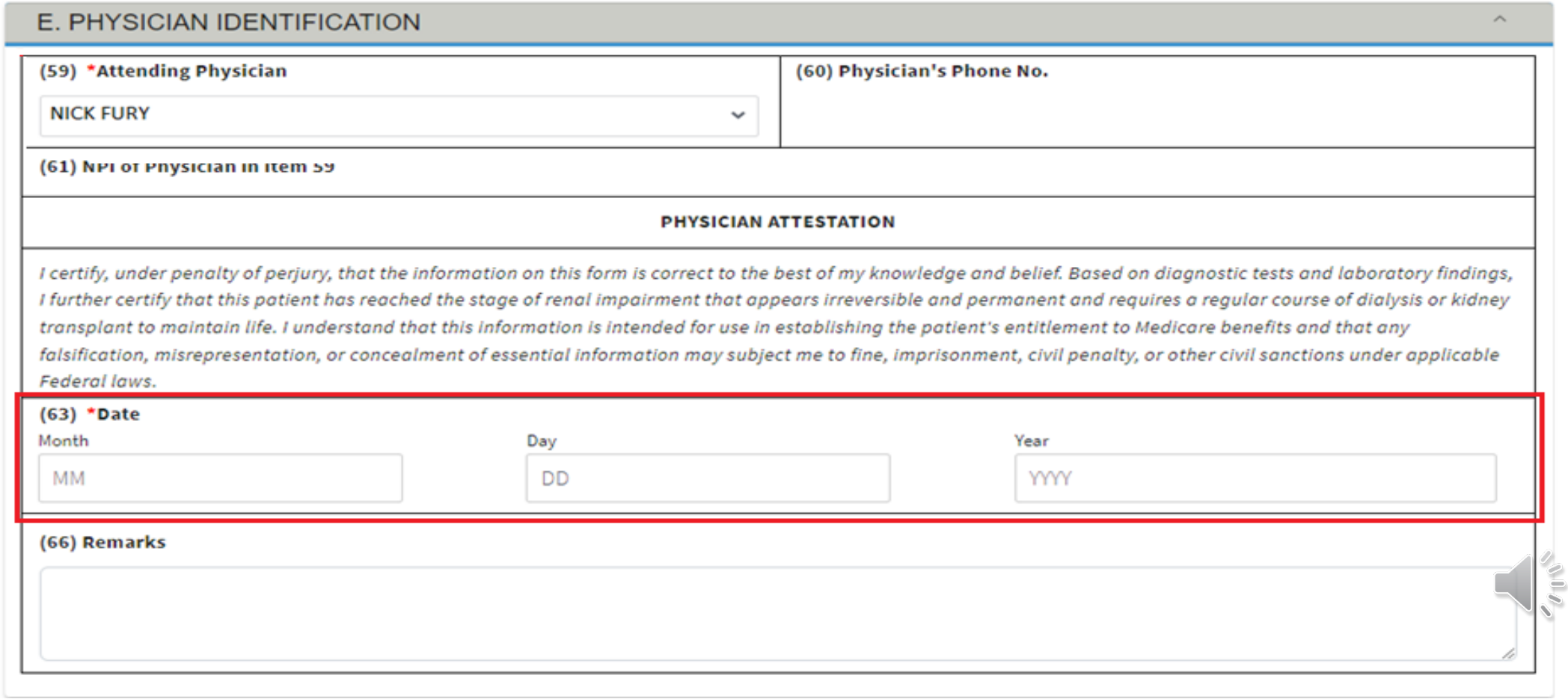


Click Edit


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

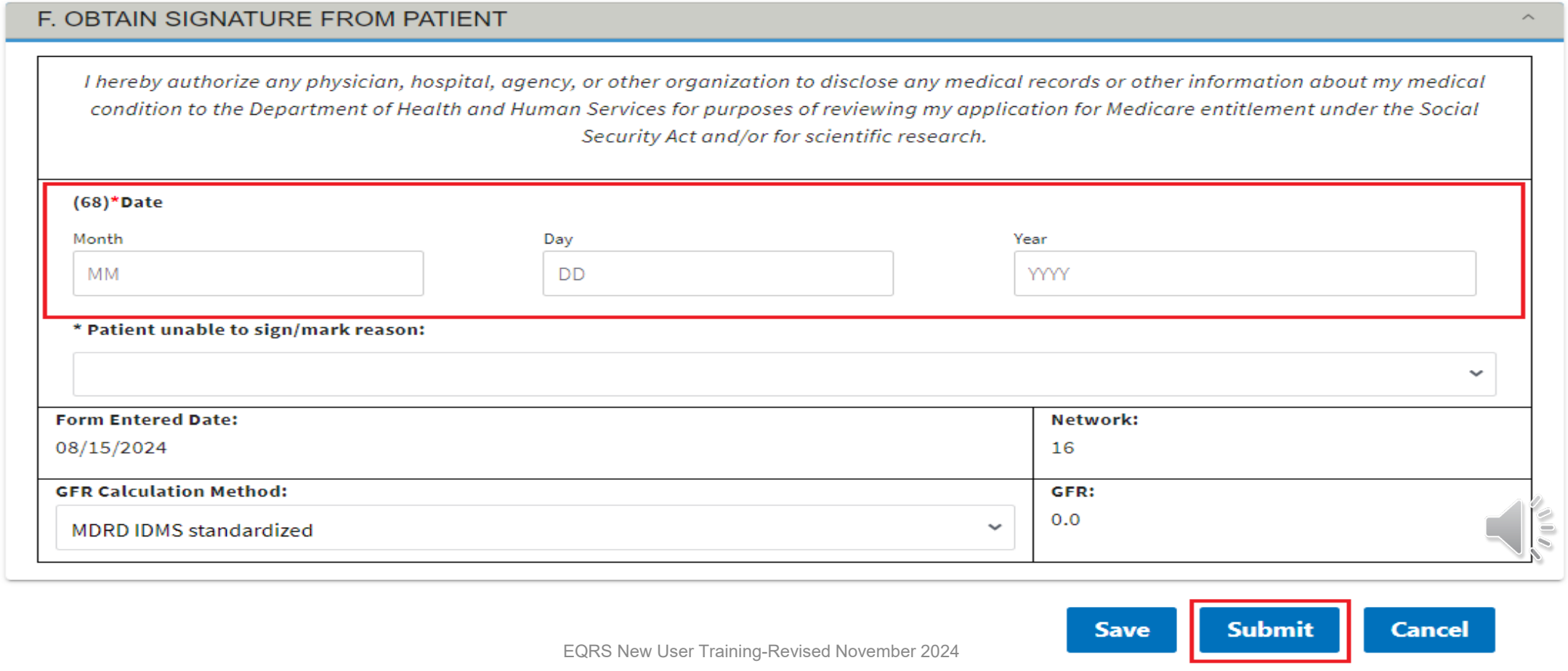
Section E

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



Section F

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



Successful Submission

EQRS displays the "**Successfully submitted form 2728**" message.