DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0048
Expires: 03/31/2027

ESRD DEATH NOTIFICATION
End Stage Renal Disease Medical Information System

Complete this ESRD Death Notification form within 2 weeks of the date of death.

- If the patient was a dialysis patient, the dialysis facility last responsible for the patient's maintenance dialysis (or home dialysis) must complete this form.
- If the patient was a transplant patient, the transplant center is responsible for completing this form.

If you can't complete this form in the CMS electronic system, forward a hard copy to the ESRD Network in your region.

1. Last name | First name | Middle initial

2. Medicare Number (if available) | 3. Social Security Number (SSN) | 4. Date of birth (mm/dd/yyyy)

5. Sex of patient ◯ Male ◯ Female | 6. Patient's State of residence (2-letter abbreviation) | 7. Date of death (mm/dd/yyyy)

8. Place of death (select one)
◯ Hospital ◯ Home ◯ Other ◯ Dialysis unit ◯ Nursing home ◯ Unknown

9. Modality at time of death (select one)
◯ Incenter hemodialysis ◯ Home hemodialysis ◯ CAPD ◯ CCPD ◯ Transplant ◯ Other

10. Name of dialysis facility/transplant center | 11. CMS Certification Number (CCN) for item 11 (6 digits)

12. Address of dialysis facility/transplant center (street address, city, state, ZIP code)

13. Causes of death (enter codes from list on form)
Primary cause of death: _____
Secondary causes of death (list up to 4): _____ _____ _____ _____ ☐ No secondary
If cause of death is other (98) specify here: _____

14. Renal replacement therapy discontinued prior to death ..... ◯ Yes ◯ No
If yes, select one of the following:
◯ Following HD and/or PD access failure ◯ Following transplant failure ◯ Following chronic failure to thrive
◯ Following acute medical complication ◯ Other
Date of last dialysis treatment: _____

15. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis? ..... ◯ Yes ◯ No ◯ Unknown ◯ Not applicable
☐ **If yes,** check here if related to hospice care.

16. Did the patient ever receive a transplant prior to death? ..... ◯ Yes ◯ No ◯ Unknown
If yes, date of most recent transplant (mm/dd/yyyy): _____
Type of transplant received (select one):
◯ Deceased donor ◯ Living related ◯ Living unrelated ◯ Multi-organ ◯ Paired exchange
Was transplant graft functioning (patient not on dialysis) at time of death? ..... ◯ Yes ◯ No ◯ Unknown
Did transplant patient resume chronic maintenance dialysis prior to death? ..... ◯ Yes ◯ No ◯ Unknown
Did the transplant patient experience a short-term course (acute) of dialysis prior to death? ..... ◯ Yes ◯ No ◯ Unknown

17. Was patient receiving palliative care/hospice care? ..... ◯ Yes ◯ No ◯ Unknown

18. Name of attending physician (print complete name)

19. Name of person submitting the form | 20. Date (mm/dd/yyyy)

ESRD DEATH NOTIFICATION FORM LIST OF CAUSES

Cardiac
23 Myocardial infarction, acute
25 Pericarditis, incl. cardiac tamponade
26 Atherosclerotic heart disease
27 Cardiomyopathy
28 Cardiac arrhythmia
29 Cardiac arrest, cause unknown
30 Valvular heart disease
31 Pulmonary edema due to exogenous fluid
32 Congestive Heart Failure

Vascular
35 Pulmonary embolus
36 Cerebrovascular accident including intracranial hemorrhage
37 Ischemic brain damage/anoxic encephalopathy
38 Hemorrhage from transplant site
39 Hemorrhage from vascular access
40 Hemorrhage from dialysis circuit
41 Hemorrhage from ruptured vascular aneurysm
42 Hemorrhage from surgery (not 38, 39, or 41)
43 Other hemorrhage (not 38-42, 72)
44 Mesenteric infarction/ischemic bowel

Infection
33 Septicemia due to internal vascular access
34 Septicemia due to vascular access catheter
45 Peritoneal access infectious complication, bacterial
46 Peritoneal access infectious complication, fungal
47 Peritonitis (complication of peritoneal dialysis)
48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
51 Septicemia due to peripheral vascular disease, gangrene
52 Septicemia, other
61 Cardiac infection (endocarditis)
62 Pulmonary infection (pneumonia, influenza)
63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

Liver Disease
64 Hepatitis B
71 Hepatitis C
65 Other viral hepatitis
66 Liver-drug toxicity
67 Cirrhosis
68 Polycystic liver disease
69 Liver failure, cause unknown or other

Gastro-Intestinal
72 Gastro-intestinal hemorrhage
73 Pancreatitis
75 Perforation of peptic ulcer
76 Perforation of bowel (not 75)

Metabolic
24 Hyperkalemia
77 Hypokalemia
78 Hypernatremia
79 Hyponatremia
100 Hypoglycemia
101 Hyperglycemia
102 Diabetic coma
95 Acidosis

Endocrine
96 Adrenal insufficiency
97 Hypothyroidism
103 Hyperthyroidism

Other
80 Bone marrow depression
81 Cachexia/failure to thrive
82 Malignant disease, patient ever on immunosuppressive therapy
83 Malignant disease (not 82)
84 Dementia, incl. dialysis dementia, Alzheimer's
85 Seizures
87 Chronic obstructive lung disease (COPD)
88 Complications of surgery
89 Air embolism
90 Accident related to treatment
91 Accident unrelated to treatment
92 Suicide
93 Drug overdose (street drugs)
94 Drug overdose (not 92 or 93)
98 Other cause of death
99 Unknown
104 Withdrawal from dialysis/uremia
105 COVID-19
106 Severe adverse medication reaction

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). Collection of your Social Security number is authorized by Executive Order 9397. Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a). The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)," published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished.

Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0048 (Expires: 03/31/2027). The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact your ESRD Network.

INSTRUCTIONS FOR COMPLETING OF ESRD DEATH NOTIFICATION: CMS-2746-U2

1. Enter the patient's legal name (last, first, middle initial). Name should appear exactly the same as it appears on patient's Social Security or Medicare card.
2. If the patient is covered by Medicare, enter his/her/their Medicare Number as it appears on his/her/their Medicare card.
3. Enter the Social Security Number as it appears on his/her/their Social Security card.
4. Enter patient's date of birth (2-digit month, day, and 4-digit year). Example 07/25/1950.
5. Fill in the appropriate circle to identify the patient's sex.
6. Enter the two-letter United States Postal Service abbreviation for state in the space provided for the patient's state of residence; e.g., MD for Maryland, NY for New York.
7. Enter patient's date of death (2-digit month, day, and 4-digit year). Example 07/25/1950.
8. Fill in one circle to indicate the location of the patient at time of death. In-transit deaths or dead on arrival (DOA) cases are to be identified by selecting "Other."
9. Fill in one circle to indicate the patient's modality at time of death. "Other" has been placed on the form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by the Office of Management and Budget.
10. Enter the name of the dialysis facility or transplant center where this patient last received care and who is completing this form.
11. Enter the 6-digit CMS Certification Number (CCN) of the dialysis facility in item 11.
12. Enter the street address of the provider submitting the form with the city, state and ZIP code in which the provider is located.
13. **Primary cause:** Enter the numeric code from the list on the form, which represents the patient's primary cause of death. Do not report the same cause of death for primary and secondary causes.

    Identify up to four secondary causes, if available. Enter the code from the list on the form, which represents the secondary cause(s) of death. If there was not secondary cause(s) of death select no secondary.

    If cause of death is "Other" (98) please specify the cause.

    Notes:
    - **Code 82:** "Malignant disease, patient ever on immunosuppressive therapy" is for use when the diagnosis of malignant disease occurred after the start of immunosuppressive therapy
    - **Code 104:** "Withdrew from dialysis" may not be reported as a primary cause of death. A primary cause of death must be selected from the list on the form which would include "Other (98)" with additional information entered.
14. Select yes or no to indicate whether or not the patient voluntarily discontinued renal replacement therapy prior to death.

    If yes, select the option that best describes the condition under which the patient discontinued renal replacement therapy:
    - Following HD and/or PD access failure
    - Following transplant failure
    - Following chronic failure to thrive
    - Following acute medical complication
    - Other (select if it was a condition of hospice)

    Enter date of last dialysis treatment.
15. Select the choice that best applies. Go to item 18 for definition of hospice.
16. Select yes if the patient ever received a kidney transplant and complete the remaining question. If the answer is no continue to question 18.

    Enter the date of the most recent transplant in month, day, and year order using an 8-digit number. If unknown, check box for unknown.

    Select the type of transplant received.

    Indicate if the transplant graft was functioning at time of the patient's death.

    Indicate if the kidney transplant failed and the transplant patient resume chronic maintenance dialysis prior to death.

    Indicate if the patient had a short-term course of dialysis to support the kidney transplant prior to death.
17. Hospice is a program of care and support for people who are terminally ill (with a life expectancy of 6 months or less, if the illness. Palliative care relieves suffering for patients with a chronic illness. Patients may receive one or the other, both, or neither.
18. Print the name of the attending physician.
19. Name of person submitting the form.
20. Date the form was signed.