

## ESRD DEATH NOTIFICATION

### END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. Name (*Last, First, Middle Initial*) \_\_\_\_\_

2. Medicare Number \_\_\_\_\_

3. Social Security Number \_\_\_\_\_

4. Date of Birth (*mm/dd/yyyy*) \_\_\_\_\_

5. Sex at Birth  
☐ Male ☐ Female

6. Gender Identity  
☐ Cisgender Man ☐ Cisgender Woman  
☐ Genderqueer/gender  
☐ Transgender man/trans man nonconforming neither exclusively  
☐ Transgender woman/trans male nor female  
woman  
☐ Additional gender category  
(or other); please specify: \_\_\_\_\_

7. Patient State of  
Residence \_\_\_\_\_

8. Date of Death \_\_\_\_\_

9. Place of Death

☐ Hospital ☐ Dialysis Facility  
☐ Home ☐ Nursing Home  
☐ Other ☐ Unknown

10. Modality at the Time of Death

☐ Incenter Hemodialysis ☐ Home Hemodialysis  
☐ CAPD ☐ CCPD  
☐ Transplant ☐ Other

11. Name of Dialysis Facility/Transplant Center \_\_\_\_\_

12. Medicare Provider Number (for item 11) \_\_\_\_\_

13. Address of Dialysis Facility/Transplant Center (*Street Address, City, State, Zip Code*) \_\_\_\_\_

14. Causes of Death (*enter codes from list on form*)

Primary Cause of Death \_\_\_\_\_ Secondary Cause of Death \_\_\_\_\_ ☐ No Secondary  
If Cause of Death is Other (98) specify here \_\_\_\_\_

15. Renal replacement therapy discontinued prior to death:  
Yes ☐ No If yes, check one of the following:  
☐ Following HD and/or ☐ Following transplant failure  
PD access failure  
☐ Following chronic ☐ Following acute medical  
failure to thrive complication  
☐ Other  
Date of last dialysis treatment (*mm/dd/yyyy*) \_\_\_\_\_

16. Was discontinuation of renal replacement therapy after ☐  
patient/family request to stop dialysis?  
☐ Yes ☐ No ☐ Unknown ☐ Not Applicable  
☐ Yes, Related to Hospice Care

17. Did the patient ever receive a transplant:  
prior to death?  
☒ Yes ☐ No ☐ Unknown  
If Yes, date of most recent transplant (*mm/dd/yyyy*) \_\_\_\_\_

18. Was patient receiving Palliative Care/Hospice care  
☐ Yes ☐ No ☐ Both ☐ Neither ☐ Unknown

Type of transplant received  
☐ Living Related ☐ Living Unrelated ☐ Deceased  
☐ Unknown

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

19. Name of Attending Physician (*Print Complete Name*) \_\_\_\_\_

20. Signature of Person Completing Form \_\_\_\_\_

21 Date \_\_\_\_\_

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. Collection of your Social Security number is authorized by Executive Order 9397.

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 0938-0448 (Expires XX/XX/XXXX). This is a mandatory to obtain a benefit ESRD Medicare information collection. The time required to complete this information collection is estimated to average 1 hour 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 Lisa Rees.

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## ESRD DEATH NOTIFICATION FORM LIST OF CAUSES

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### 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 Hyponatremia
- 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
- 104 Withdrawal from dialysis/uremia
- 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 Covid-19

100 Severe Adverse Medication Reaction

101 Unknown

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

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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 Beneficiary Identifier (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. Check the appropriate block to identify sex at birth.
6. Check the appropriate block to indicate the gender the patient identifies as.
7. 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.
8. Enter patient's date of death (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
9. Check the one block which indicates the location of the patient at time of death. In-transit deaths or dead on arrival (DOA) cases are to be identified by checking "Other."
10. Check the one block, which indicates 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.
11. Enter the name of the dialysis facility or transplant center where this patient last received care and who is completing this form.
12. Enter the 6-digit Medicare identification code of the dialysis facility in item 11.
13. Enter the street address of the provider submitting the form with the City, State and Zip Code in which the provider is located.
14. 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 check no secondary.

If cause of death is "Other" (101) 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 (101)" with additional information entered.

15. 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.

16. Select the choice that best applies. See item 18 for definition of hospice.
17. 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.

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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.

18. 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.

19. Print the name of the attending physician.

20. Signature of the person completing the
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form.

21. Date the form was signed.

**Complete the ESRD Death Notification, CMS-2746, 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 are unable to complete this form in the approved CMS electronic system, forward a hard copy to the ESRD Network in your region.**

**The form CMS-2746 can be downloaded from CMS.gov or obtained from the ESRD Network in your region.**

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<p>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).</p>
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