Form Approved
OMB No. 0938-0448

ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. Patient's Last Name | First | MI
2. Medicare Claim Number

3. Patient's Sex
   a. ☐ Male b. ☐ Female
4. Date of Birth __ __ / __ __ / __ __ __ __ (Month Day Year)
5. Social Security Number

6. Patient's State of Residence
7. Place of Death
   a. ☐ Hospital b. ☐ Dialysis Unit c. ☐ Home d. ☐ Nursing Home e. ☐ Other
8. Date of Death __ __ / __ __ / __ __ __ __ (Month Day Year)

9. Modality at Time of Death
   a. ☐ Incenter Hemodialysis b. ☐ Home Hemodialysis c. ☐ CAPD d. ☐ CCPD e. ☐ Transplant f. ☐ Other

10. Provider Name and Address (Street)
11. Provider Number

Provider Address (City/State)

12. Causes of Death (enter codes from list on back of form)
   a. Primary Cause __ __ __
   b. Were there secondary causes?
      ☐ No
      ☐ Yes, specify: __ __ __ __ __ __ __ __ __ __ __ __
   C. If cause is other (98) please specify:____________________

13. Renal replacement therapy discontinued prior to death: ☐ Yes ☐ No

   If yes, check one of the following:
   a. ☐ Following HD and/or PD access failure
   b. ☐ Following transplant failure
   c. ☐ Following chronic failure to thrive
   d. ☐ Following acute medical complication
   e. ☐ Other
   f. Date of last dialysis treatment __ __ / __ __ / __ __ __ __ (Month Day Year)

14. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?
   ☐ Yes ☐ No
   ☐ Unknown ☐ Not Applicable

15. If deceased ever received a transplant:
   a. Date of most recent transplant __ __ / __ __ / __ __ __ __ (Month Day Year) ☐ Unknown
   b. Type of transplant received
      ☐ Living Related ☐ Living Unrelated ☐ Deceased ☐ Unknown
   c. Was graft functioning (patient not on dialysis) at time of death?
      ☐ Yes ☐ No ☐ Unknown
   d. Did transplant patient resume chronic maintenance dialysis prior to death?
      ☐ Yes ☐ No ☐ Unknown

16. Was patient receiving Hospice care prior to death?
   ☐ Yes ☐ No
   ☐ Unknown

17. Name of Physician (Please print complete name)
18. Signature of Person Completing This Form | Date

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). 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).

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
- 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 Unknown

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. The time required to complete this information collection is estimated to average 30 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

INSTRUCTIONS FOR COMPLETING OF ESRD DEATH NOTIFICATION
CMS-2746-U2 (10/04)

ITEM	PROCEDURES

1. **Patient's Last Name, First, and Middle Initial**
   Enter the patient's last name, first name, and middle initial as it appears on the Medicare Card or other official SSA notification.

2. **Medicare Claim Number**
   Enter the patient's Medicare number as it appears on the Medicare Card or other official SSA notification.

3. **Patient's Sex**
   Check the box that indicates the patient's sex.

4. **Date of Birth**
   Enter the date in month, day, and year order, using an 8-digit number; e.g., 07/24/2000 for July 24, 2000.

5. **Social Security Number**
   Enter the patient's own social security number.

6. **Patient's State of Residence**
   Enter the two-letter United States Postal Service abbreviation for State in the space provided; e.g., MD for Maryland, NY for New York.

7. **Place of Death**
   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."

8. **Date of Death**
   Enter the date in month, day, and year order, using an 8-digit number.

9. **Modality at Time of Death**
   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.

10. **Provider Name and Address (City and State)**
    Enter the complete name of the provider submitting the form and the city and State in which the provider is located.

11. **Provider Number**
    Enter the provider number (6-digit Medicare identification code) assigned by the Centers for Medicare & Medicaid Services.

12. **Causes of Death**
    a. 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.
    b. Were there secondary causes?
       Check the one block, which indicates whether or not there were secondary cause(s) of death. If yes, enter the code from the list on the form, which represents the secondary cause(s) of death.
    c. If cause is "Other" (98) please specify.

NOTES:

1. Code 82, "Malignant disease, patient ever on immunosuppressive therapy" means immunosuppressive therapy prior to the diagnosis of malignant disease.
2. Code 104, "Withdrew from dialysis" may not be reported as a cause of death (e.g., Code 98; "Other") and specify.

13. **Renal Replacement Therapy Discontinued Prior to Death Indicate Yes / No**
Check the one block, which indicates whether or not the patient voluntarily discontinued renal replacement therapy prior to death.

If YES, check one of the following:

Check the one box, which best describes the condition under which the patient discontinued renal replacement therapy.

a. Following HD and/or PD access failure
b. Following transplant failure
c. Following chronic failure to thrive
d. Following acute medical complication
e. Other
f. Enter date of last dialysis treatment using an 8-digit number

14. **Was Discontinuation of Renal Replacement Therapy after Patient/Family Request to Stop Dialysis**
Check the appropriate box that applies. Yes / No / Unknown / or Not Applicable

15. **If Deceased Ever Received a Transplant**
If the patient had ever received a transplant, complete items a through d.

a. Date of most recent transplant

   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.

b. Type of transplant received
   Check the block that indicates type of transplant received.

c. Was graft functioning at time of death?
   Check appropriate block Yes / No or Unknown.

d. Did transplant patient resume chronic maintenance dialysis prior to death? Check appropriate block Yes / No or Unknown.

16. **Was Patient Receiving Hospice Care Prior to Death?**
Check appropriate block Yes / No or Unknown.

17. **Name of Physician**
Enter the name of the physician supplying the information for this form.

18. **Signature of Person Completing This Form**
The person completing the form should sign this space. The date should be entered.

Distribution of Copies:
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.

Mail the original (GREEN) copy to the ESRD network.

Retain the facility (WHITE) copy at your facility.

The form CMS-2746 can be obtained from your ESRD Network office.