

Request to Review Possible Duplicate and admit Patient into CROWNWeb



ESRD ALLIANCE | NETWORK 16

Purpose: This form is for Network 16 to assist facilities in admitting a patient into CROWNWeb after receiving a "Possible Duplicate" error.

Do NOT EMAIL THIS FORM. Emails will be reported to CMS as Security Violations.

Fax this completed form to the Data Department at 206-923-0716. **Incomplete or handwritten forms will not be processed.** Every field is **required**. Please allow five business days for processing.

FACILITY INFORMATION			
CCN/Medicare Provider Number and Facility Name			
Name/Email/Phone Number of person completing this form			
PATIENT INFORMATION			
Social Security Number (SSN)	<input type="checkbox"/> N/A	Medicare Claim Number (HIC/MBI)	<input type="checkbox"/> N/A
UPI (If Known)	Phone Number		
First Name	Date of Birth		
Last Name	Gender		
Admit Date (Date first dialyzed at this facility)			
Admit Reason (Choose One)	<input type="checkbox"/> New ESRD Patient <input type="checkbox"/> Dialysis After a Transplant Failed <input type="checkbox"/> Restart <input type="checkbox"/> Transfer In <input type="checkbox"/> Dialysis in Support of Transplant		
Transient Status (Choose One)	<input type="checkbox"/> No <input type="checkbox"/> Yes - Facility Maintenance <input type="checkbox"/> Yes - Home Maintenance <input type="checkbox"/> Yes - Travel <input type="checkbox"/> Yes - Disaster <input type="checkbox"/> Yes - Back-up Hemodialysis <input type="checkbox"/> Yes - Training <input type="checkbox"/> Yes - Dialysis in Support of Transplant		
Primary Dialysis Setting	<input type="checkbox"/> Home <input type="checkbox"/> Dialysis Facility/Center <input type="checkbox"/> Skilled Nursing Facility/LTC Facility		
Dialysis Time Period	<input type="checkbox"/> Nocturnal <input type="checkbox"/> Daytime	Expected Self-care Setting (For SELF-CARE Only)	<input type="checkbox"/> Home <input type="checkbox"/> In-center
Primary Type of Treatment (Select one)	<input type="checkbox"/> Hemodialysis-----> Sessions per week:----- Minutes per session:----- Training Start Date:----- Training End Date:-----		
	<input type="checkbox"/> CAPD <input type="checkbox"/> CAPD Training-> Training Start Date:----- Training End Date:-----		
	<input type="checkbox"/> CCPD <input type="checkbox"/> CCPD Training-> Training Start Date:----- Training End Date:-----		
Nephrologist			
Patient's Self-Reporting of Race & Ethnicity?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnicity (select one)	<input type="checkbox"/> Hispanic/Latino* Country/Area of Origin (Required)		<input type="checkbox"/> Non-Hispanic/Latino
Race (select ALL that apply)	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander* *Country of Origin (Required)----- <input type="checkbox"/> American Indian/Alaskan Native** **Name of Enrolled/Principal Tribe (Required)-----		
PATIENT CONTACT INFORMATION			
<input type="checkbox"/> Do Not Contact Patient		<input type="checkbox"/> Physical Address Same as Mailing	
Mailing Address		Physical Address	
ZIP Code, City, State		ZIP Code, City, State	
MISC PATIENT INFO			
Citizenship	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Non-U.S. Citizen <input type="checkbox"/> U.S. Resident <input type="checkbox"/> Foreign National U.S. Resident		
Medicare Enrollment Status	<input type="checkbox"/> Currently Enrolled Medicare Coverage <input type="checkbox"/> No Medicare Coverage <input type="checkbox"/> Medicare Application Pending		
School Status	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not in School		
Vocational Rehabilitation	<input type="checkbox"/> Referred to Voc Rehab <input type="checkbox"/> Currently in Voc Rehab <input type="checkbox"/> Completed Voc Rehab <input type="checkbox"/> Not Eligible for Voc Rehab <input type="checkbox"/> Declined Voc Rehab		
Employment (select one)	<input type="checkbox"/> Unemployed <input type="checkbox"/> Retired (Disabled) <input type="checkbox"/> Retired (Age/Preference) <input type="checkbox"/> Student <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Medical Leave <input type="checkbox"/> Homemaker		

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