HealthInsight
ESRD ALLIANCE | NETWORK 18
Serving Southern California

Request to Review Possible Duplicate and admit Patient into CROWNWeb

Purpose: This form is for Network 18 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 855.580.4876. **Incomplete 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 and Phone Number of Person Completing this Form			
PATIENT INFORMATION			
Social Security Number (SSN)			☐ N/A
Medicare Claim Number (HIC)			☐ N/A
First Name		**Date of Birth**	
Last Name		**Gender**	
Admit Date (date first dialyzed at this facility)			
Admit Reason (choose one)	☐ New ESRD Patient ☐ Dialysis After a Transplant Failed ☐ Restart ☐ Transfer In ☐ Dialysis in Support of Transplant		
Transient Status	☐ No ☐ Yes - Facility Maintenance ☐ Yes - Home Maintenance ☐ Yes - Travel ☐ Yes - Disaster ☐ Yes - Back-up Hemodialysis ☐ Yes - Training ☐ Yes - Dialysis in Support of Transplant		
Treatment Start Date			
Primary Dialysis Setting	☐ Home ☐ Dialysis Facility/Center ☐ Skilled Nursing Facility/LTC Facility		
Dialysis Time Period	☐ Nocturnal ☐ Daytime		
Expected Self-care Setting *(for SELF-CARE only)*	☐ Home ☐ In-center		
Primary Type of Treatment *(select one)*	☐ Hemodialysis Sessions per week: _____ Minutes per session: _____ ☐ CAPD ☐ CAPD Training Start Date: _____ Training End Date: _____ ☐ CCPD ☐ CCPD Training Start Date: _____ Training End Date: _____ ☐ Other *(specify):*		
Attending Practitioner's Name			
Patient's Self-Reporting of Race & Ethnicity?	☐ Yes ☐ No		
Ethnicity *(select one)*	☐ Not Hispanic ☐ Hispanic/Latino: Country/Area of Origin:		
Race *(select ALL that apply)*	☐ White ☐ Black or African American ☐ Asian ☐ American Indian (AI)/Alaskan Native (AN)** ☐ Native Hawaiian/Pacific Islander **Name of Enrolled/Principal Tribe:		
☐ Do Not Contact Patient	**Mailing Address**	**Physical Address**	☐ Same As Mailing Address
Street			
ZIP Code			
City, State			
Citizenship	☐ U.S. Citizen ☐ Foreign National U.S. Resident ☐ Non U.S. Citizen ☐ U.S. Resident		
Medicare Enrollment Status	☐ Currently Enrolled in Medicare Coverage ☐ Medicare Application Pending ☐ No Medicare Coverage		
School Status	☐ Full Time ☐ Part Time ☐ Not in School		
Vocational Rehabilitation	☐ Referred to VR ☐ Currently in VF ☐ Completed VR ☐ Not Eligible ☐ Declined VR		
Employment	☐ Unemployed ☐ Retired (Disabled) ☐ Medical Leave ☐ Homemaker ☐ Employed Full Time ☐ Employed Part Time ☐ Student ☐ Retired Age/Preference		