Request to Review Possible Duplicate and admit Patient into CROWNWeb

Comagine Health
ESRD ALLIANCE | NETWORK 18

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 888-280-8669. **Incomplete or handwritten forms will not be processed.**
Every field is **required**. Please allow five business days for processing.

DO NOT EMAIL

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FACILITY INFORMATION	
CCN/Medicare Provider Number and Facility Name	
Name/Email/Phone Number of person completing this form	

PATIENT INFORMATION			
Social Security Number *(SSN)*	☐ N/A	**Medicare Claim Number** *(HIC/MBI)*	☐ 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)*	☐ New ESRD Patient ☐ Transfer In ☐ Dialysis After a Transplant Failed ☐ Dialysis in Support of Transplant ☐ Restart		
Transient Status *(Choose One)*	☐ No ☐ Yes - Facility Maintenance ☐ Yes - Travel ☐ Yes - Back-up Hemodialysis ☐ Yes - Dialysis in Support of Transplant ☐ Yes – Home Maintenance ☐ Yes - Disaster ☐ Yes - Training		
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:_____ Training Start Date:_____ Training End Date:_____ ☐ CAPD ☐ CAPD Training-→ Training Start Date:_____ Training End Date:_____ ☐ CCPD ☐ CCPD Training-→ Training Start Date:_____ Training End Date:_____		
Nephrologist			
Patient's Self-Reporting of Race & Ethnicity?	☐ Yes ☐ No		
Ethnicity *(select one)*	☐ Hispanic/Latino* Country/Area of Origin **(Required)** _____		☐ Non-Hispanic/Latino
Race *(select ALL that apply)*	☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander* ***Country of Origin (Required)**_____ ☐ American Indian/Alaskan Native** ****Name of Enrolled/Principal Tribe (Required)** _____		

PATIENT CONTACT INFORMATION	
☐ Do Not Contact Patient	☐ Physical Address Same as Mailing
Mailing Address	Physical Address
ZIP Code, City, State	ZIP Code, City, State

MISC PATIENT INFO			
Citizenship	☐ U.S. Citizen ☐ U.S. Resident	☐ Non-U.S. Citizen ☐ Foreign National U.S. Resident	
Medicare Enrollment Status	☐ Currently Enrolled Medicare Coverage ☐ Medicare Application Pending	☐ No Medicare Coverage	
School Status	☐ Full Time	☐ Part Time	☐ Not in School
Vocational Rehabilitation	☐ Referred to Voc Rehab ☐ Not Eligible for Voc Rehab	☐ Currently in Voc Rehab ☐ Declined Voc Rehab	☐ Completed Voc Rehab
Employment *(select one)*	☐ Unemployed ☐ Employed Full Time	☐ Retired (Disabled) ☐ Employed Part Time	☐ Retired (Age/Preference) ☐ Medical Leave ☐ Student ☐ Homemaker