Request to Admit a Patient into a Transplant Center

Purpose: This form is to request assistance admitting a patient to your Transplant Center in CROWNWeb.

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.

FACILITY INFORMATION	
CCN and Facility Name	
Name of person completing form	
Phone/email of person completing form	

PATIENT INFORMATION			
Social Security Number:	☐ N/A	**Medicare Claim Number/MBI:**	☐ N/A
First Name		**Last Name**	
Date of Birth		**Gender**	
Transplant Date		**Transplant Status:**	☐ Functioning ☐ Non-Functioning
Prior Chronic Outpatient Dialysis or Kidney Transplant?	☐ Yes ☐ No		
Primary Type of Transplant	☐ Living Related ☐ Living Un-Related ☐ Deceased		
Attending Practitioner			

RACE & ETHNICITY (Complete this section only if patient has never treated as ESRD at another facility)		
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 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 ☐ Non-U.S. Citizen ☐ U.S. Resident ☐ Foreign National U.S. Resident
Medicare Enrollment Status	☐ Enrolled in Medicare Coverage ☐ No Medicare Coverage ☐ Medicare Application Pending
Employment *(select one)*	☐ Unemployed ☐ Retired (Disability) ☐ Retired (Age/Preference) ☐ Student ☐ Employed Full Time ☐ Employed Part Time ☐ Medical Leave of Absence ☐ Homemaker

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