Near Match Form

The information below is the minimum required by EQRS to admit patient.

FACILITY INFORMATION		
CCN/Medicare Provider Number		
Facility Name		
Person Completing this Form		
Alliant EQRS Service Desk Ticket #		
PATIENT INFORMATION		
Social Security Number		
Medicare Claim Number		
First Name		
Last Name		
Date Of Birth		
Gender		
Admit Date *(date first dialyzed at this facility)*		
Admit Reason (Choose One)		○ **New ESRD Patient** ○ **Transfer In** ○ **Restart** ○ **Dialysis After Transplant Failed** ○ **Dialysis in Support of Transplant**
		☐
ADD TREATMENT INFORMATION		
Primary Dialysis Setting		○ **Home** ○ **Dialysis Facility/Center** ○ **SNF/ Long Term Care Facility**
Dialysis Time Period		○ **Nocturnal** ○ **Daytime**
Primary Type of Treatment		○ **Hemodialysis** ○ **CAPD** ○ **CCPD** ○ **Other (Specify)**_____
If *Hemo*, **Sessions Per Week**		
If *Hemo*, **Time Per Session** *(in minutes)*		
Attending Practitioner		
Attending Practitioner's UPIN/NPI		
PATIENT CONTACT INFO		
Mailing Address	**Street Address**	
	Zip Code	
	City	
	State	
Physical Address Same as Mailing Address		☐ **Yes**
Physical Address	**Street Address**	
	Zip Code	
	City	
	State	

Emailing a completed form is a violation of CMS Security Policy. All violations are reported to CMS. COMPLETE FORM AND FAX to ESRD Network 8 &14 Fax: 972-503-3219 or 601-932-4446