ALLIANT HEALTH SOLUTIONS | END STAGE RENAL DISEASE NETWORKS 8 & 14

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	
Sex: M/F	
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 INFORMATION		
Mailing Address	Street Address	
	City	
	State	
	Zip Code	
Physical Address Same a Mailing Address?		☐ Yes ☐ No
Physical Address	Street Address	
	City	
	State	
	Zip Code	

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