ALLIANT HEALTH SOLUTIONS | END STAGE RENAL DISEASE NETWORKS 7 | 8 | 13 | 14

Agreement Between

_____ _____

Facility Name Provider number

(required) AND

ESRD Network _____

The undersigned, on behalf of _____

(Facility Name)

hereby joins other Medicare-certified End-Stage Renal Disease facilities in the ESRD Network in agreeing to participate in the activities of the Network as provided in 42 CFR Part 494.180(i) of Department of Health and Human Services regulations.

It is understood that participation in Network activities is a condition of approval to receive Medicare reimbursement for the provision of End Stage Renal Disease services.

The dialysis facility must cooperate with the ESRD Network designated for its geographic area in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD Network activities and pursue Network goals. Failure to comply may result in sanctions by CMS.

Signed _____

(Authorized Representative of Facility)

Date _____

The undersigned acknowledges this document as an agreement between

_____, and ESRD Network _____

(Facility name)

Signed _____

Deputy Director, ESRD Network 7, 8, 13, & 14

Date _____