



# PRELIMINARY EVIDENCE REPORT CHECKLIST



RENAL DIALYSIS

**This checklist constitutes the requirements of the Preliminary Evidence Report (PER), which is mandatory for organizations applying for initial Renal Dialysis accreditation.**

Review and acknowledge that all of the following requirements have been met and submit this signed checklist with the required items listed below.

**Verification of the following is required for organizations seeking an initial Medicare Provider Number:**

- The organization has completed the CMS-855 application and received written confirmation the application has been “processed” and “the application is being forwarded with a recommendation to the state and CMS Regional Office.”
  - **Submit a copy of the letter from CMS or the Medicare Administrative Contractor (MAC). This is applicable for organizations seeking an initial Medicare Provider Number.**
- A copy of CMS form 3427.
  - **Submit a copy of the form.**
- A signed agreement between the organization and applicable End-Stage Renal Disease (ESRD) network.
  - **Submit a copy of the ESRD Network agreement. (A signed agreement between the facility and the applicable Network is required prior to the initial certification survey (V755).)**
- The organization can demonstrate they are able to provide all services needed by patients being served and is able to demonstrate operational capacity of all facets of the organization
- Life Safety Code (LSC) attestation or waiver, if applicable.
  - **Submit a copy of the waiver. (If a facility does not meet the qualifications for a waiver, a LSC Survey must be completed.)**
- Isolation Room Waiver, if applicable
  - **If the organization is requesting an Isolation Room Waiver, a copy of the paperwork submitted to CMS for this request must be sent to ACHC.**
- The organization must have one patient on the census for each modality offered.
- The organization has a full and current license, NOT PROVISIONAL, in the state it is currently doing business, if applicable.
  - **Please note: all states may not require a license therefore this only pertains to organizations that reside in states that require a license.**

**Confirmation of the following (initial in spaces provided):**

\_\_\_\_\_ I attest that this organization possesses all policies and procedures as required by the ACHC Accreditation Standards.

\_\_\_\_\_ I acknowledge that this organization was/is/will be in compliance with ACHC Accreditation Standards as of \_\_\_\_\_ date.



Your organization will be placed into scheduling once this document, the Agreement for Accreditation Services and Business Associate Agreement are submitted to your Account Advisor and payments are up to date. ACHC will strive to conduct your survey as soon as possible.

**\*\*PLEASE NOTE: YOUR ORGANIZATION MUST ALWAYS BE IN COMPLIANCE WITH MEDICARE REGULATIONS, CONDITIONS FOR COVERAGE, AND APPROPRIATE STATE REGULATIONS.**

I, having the authority to represent this organization, verify that

\_\_\_\_\_ (organization's legal name)

has met the above requirements for survey. If this organization fails to meet any of the aforementioned requirements when the ACHC Surveyor arrives for your survey, the survey performed by ACHC will not be accepted as a legitimate Initial Medicare Certification Survey by CMS. This will result in additional charges to the organization for a subsequent survey to be performed when the organization has notified ACHC it has met all of the above requirements.

\_\_\_\_\_  
(Name) (Title)

\_\_\_\_\_  
(Date) (Signature)