



DIALYSIS FACILITY PARTICIPATION AGREEMENT

Facility Name _____ Provider Number (Required) _____

AND

Heartland Kidney Network

The Undersigned, on behalf of _____ hereby agrees to participate and cooperate with the goals and activities, including quality improvement projects, as set forth by Heartland Kidney Network as provided in 42 CFR Part 494.180.V772 (i) of Centers for Medicare & Medicaid Services (CMS) 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 ESRD Network designed 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.

Authorized Representative of Facility (Unit Administrator, Medical Director or Facility Representative)

Signature: _____

Print Name: _____

Date: _____

Executive Director at Heartland Kidney Network

Signature: *Shane Perry*

Print Name: Shane Perry

Date: _____

Revised March 2015



Instructions for Completing Facility Agreement Document

The Conditions for Coverage, enacted in October 2008, require that facility agreements be implemented between each Network and facilities in the Network region.

Directions:

1. Enter the facility name indicated on the form (this is the “doing business as” name)
2. Enter the Medicare provider number issued by CMS
3. Print one (1) copy of the form and have it signed by the person authorized by the governing body to execute such agreements.
4. Keep a copy for your facility records.

Note: The Network Executive Director has already signed off on the document.

This form is also available at the Network website. www.heartlandkidney.org