Patient Name: _____

ABC Patient ID #: _____

Patient Instructions for Home Medical Equipment

In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

1. Receive copy of ABC Health Care "Home Medical Equipment – Instructions & Documentation Requirements" packet
   - ☑ Completed

2. Fill out the "ABC Health Care Patient Information Record" document
   - ☐ Completed

3. Using the "Written Order Requirements" document, confirm your prescription / "written order" meets the Medicare-provided requirements. If not, contact your prescribing physician for a new prescription / written order or make the appropriate changes to your existing prescription
   Important, please note - All edits to an existing prescription must be initialed and dated by the signing physician.
   - ☐ Completed

4. Using the "Equipment Documentation Requirements" document, confirm all Medicare-required documentation is included. If not, contact your physician to request the Medicare-required medical documentation.
   Important, please note - Medical documentation written on a prescription / written order is not accepted by Medicare. It must be separate documentation provided from your medical records or medical history with a healthcare provider.
   - ☐ Completed

5. Submit all of the following to ABC's DME department. It will be scanned and returned to you.
   - ☐ Patient Instruction form
   - ☐ Patient Information Record form
   - ☐ Valid Written Order
   - ☐ Equipment Documentation form
   - ☐ Equipment Documentation

6. An ABC Health Care Medicare Quality Assurance associate will review the order and documentation within 48 hours of submission.
   - ☐ If order and documentation are not complete, the Medicare Quality Assurance associate will deny the request for equipment and inform you of reasons.
   - ☐ If order and documentation are complete, the Medicare Quality Assurance associate will approve the request for equipment and inform you of approval and process for receiving your equipment.
     Important, please note – ABC will only provide equipment after patient co-payment, deductible, and/or prior balance is collected.

7. ABC Health Care will file your medical equipment claim with Medicare for you and an Explanation of Benefits from CMS will follow to confirm billing is complete.

Patient Information Record

Date:_____

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Date of Birth: _____ SS#: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Cell phone:_____ Work phone: _____

Home phone:_____ Email:_____

Caregiver / Responsible Party Information:

Last Name:_____ First Name:_____ MI:_____

Cell phone:_____ Work phone: _____

Home phone:_____ Email:_____

Clinical Information:

Gender: ☐Male ☐Female Height:_____ Weight:_____

Health / Infection Risk: ☐Yes ☐ No If Yes, provide detail:_____

Primary Care Physician:_____

PCP Address: _____

City:_____ State:_____ Zip:_____

Health Insurance Information:

Primary Insurance Company:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Secondary Insurance Comapny:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Tertiary Insurance Company:_____

Policy Number:_____ Group Number:_____

Subscriber Name:_____

Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:_____

Written Order Requirements – Medicare

Example #1 – Ambulatory Item

Per Medicare and the Affordable Care Act, a detailed written order for DME items must be (A) received before the delivery of an item can take place and (B) must include the following information (as shown in the example below):

1. Beneficiary's name
2. Physician's name
3. Physician's NPI
4. Date of the order
5. Detailed description of the item(s) with additional details, as applicable:
    a. Detailed description of item(s) to be dispensed (with HCPC codes, if possible)
    b. Quantity to be dispensed
    c. Frequency of use
    d. Duration / Length of need
    e. Number of refills
    f. Route of administration (primarily only for respiratory items)
    g. Dosage & concentration (primarily only for respiratory items)
6. Physician signature
7. Physician signature date

James S. Doe, M.D. (2)
123 Market Street, Hampton, VA 23666
Phone: (757) 555-1212
(3) **NPI# 1234567890**

Name: Robert Jones (1) Date: 07/01/2016 (4)

Address: 1411 Green Place, Chesapeake, VA 23324 DOB: 05/19/1945

(5)

(a) Lightweight wheelchair (K0003) with elevated leg rests (K0195), anti-tippers (E0971), seat cushion (E2601) and back cushion (E2611) for daily ambulation use.

Refills: 0 (e) Quantity: 1 (b) Length of Need: 99 months (d)

Signature of Prescriber: James S Doe (6) Signature Date: 07/01/2016 (7)

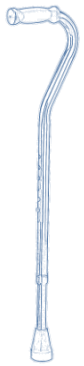
IMPORTANT – Any / each change made to prescription that is already signed, must be initialed and dated by the physician to be accepted by Medicare

Equipment Requirements & Check-Off List

• Canes •

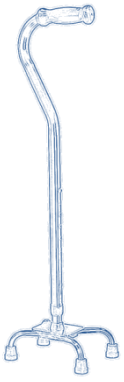
In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

Single Point Cane



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0100 Single Point cane"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- Documentation within the medical chart from physician detailing:
  - ☐ Patient is incapable of functional independent ambulation due to specific diagnosis.
  - ☐ Diagnosis (and/or associated symptom) significantly impairs ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.
  - ☐ Without cane, can only safely ambulate ____ feet (specify distance).
  - ☐ The functional mobility deficit can be sufficiently resolved by use of cane.
  - ☐ Patient is willing and able to safely use the cane for MRADL's in the home.

Quad Cane



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0105 Quad cane"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- Documentation within the medical chart from physician detailing:
  - ☐ Patient is incapable of functional independent ambulation due to specific diagnosis.
  - ☐ Diagnosis (and/or associated symptom) significantly impairs ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.
  - ☐ Without cane, can only safely ambulate ____ feet (specify distance).
  - ☐ The functional mobility deficit can be sufficiently resolved by use of cane.
  - ☐ Patient is willing and able to safely use the cane for MRADL's in the home.

Detailed Description Information

Includes HCPC codes, product descriptions for all bases, attachments, and miscellaneous parts – all as defined by Medicare regulations:

Code	Description, as defined by Medicare	Additional criteria
A4636	REPLACEMENT, HANDGRIP, CANE EACH	Replacement part only
A4637	REPLACEMENT, TIP, CANE EACH.	Replacement part only