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 for Standard Bedside Commode

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

Rx

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

(3) **NPI# 1234567890**

Name: ROBERT JONES (1) Date: 05/01/2018 (4)
Address: 1411 GREEN PLACE, CHESAPEAKE, VA 23324 DOB: 05/16/1945

(5)

(a) BEDSIDE COMMODE (E0136) FOR DAILY USE

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

Signature of Prescriber: [signature] (6) Signature Date: 05/01/2018 (7)

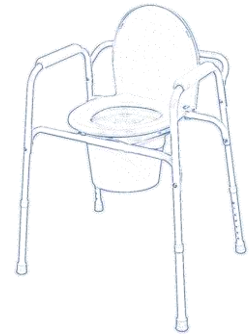
**IMPORTANT** – *Any / each change made to prescription that is already signed, **must** be initialed and dated by the physician to be accepted by Medicare*

Equipment Requirements & Check-Off List

• Commodes •

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.

Bedside Commode - Standard



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0163 Bedside commode"
  - ☐ 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:
  - ☐ Diagnosis (and/or associated symptom) makes patient physically incapable of utilizing regular toilet facilities in the home and is room confined (***one (1) of the below statements must be included to validate patient's inability to access "regular toilet facilities" as "room confined"):
    - ☐ Patient is confined to a single room
    - ☐ Patient is confined to one level of the home and there is no toilet on that level
    - ☐ Patient is confined to the home and there are no toilet facilities in the home
  - ☐ Commode will help patient access regular toilet facilities
  - ☐ No other treatment options are available for this patient.
  - ☐ Patient is willing and able to safely use the commode in the home.

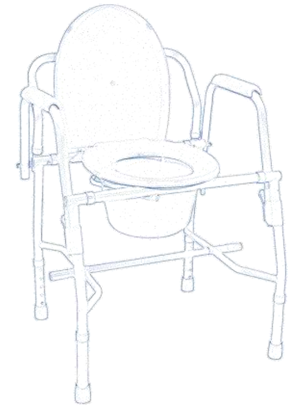
Bedside Commode – Heavy Duty

- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0168 Heavy duty bedside commode"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature

(Continued on next page)

- <u>Documentation within the medical chart from physician detailing for HD Commode:</u>
  - ☐ Diagnosis (and/or associated symptom) makes patient physically incapable of utilizing regular toilet facilities in the home and is room confined (***one of the below statements must be included to validate patient's inability to access "regular toilet facilities" as "room confined"):
    - ☐ Patient is confined to a single room
    - ☐ Patient is confined to one level of the home and there is no toilet on that level
    - ☐ Patient is confined to the home and there are no toilet facilities in the home
  - ☐ Commode will help patient access regular toilet facilities
  - ☐ No other treatment options are available for this patient.
  - ☐ Patient is willing and able to safely use the commode in the home.
  - ☐ Patient weight was ____ (enter weight; must be over 300 lbs) pounds on ____ (specify date; must be within one month of receipt of commode).

Drop Arm Commode



- <u>Detailed Written Order Requirements:</u>
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0165 Drop arm commode"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- <u>Documentation within the medical chart from physician detailing:</u>
  - ☐ Diagnosis (and/or associated symptom) makes patient physically incapable of utilizing regular toilet facilities in the home and is room confined (***one (1) of the below statements must be included to validate patient's inability to access "regular toilet facilities" as "room confined"):
    - ☐ Patient is confined to a single room
    - ☐ Patient is confined to one level of the home and there is no toilet on that level
    - ☐ Patient is confined to the home and there are no toilet facilities in the home
  - ☐ Detachable arms feature is necessary (one or both is required to qualify):
    - ☐ To facilitate transferring the patient to toilet
    - ☐ Patient has a body configuration that requires extra width
  - ☐ Commode will help patient access regular toilet facilities.
  - ☐ The room confinement is not corrected with a bedside commode but can be sufficiently resolved by use of a drop arm commode.
  - ☐ Patient is willing and able to safely use the commode in the home.

Raised Toilet Seat

Medicare will not pay for raised toilet seats because they are a "non-covered" item. They will need to be purchased privately. They are available for purchase at all ABC locations. Pricing available upon request.