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" written by your physician meets the insurance-driven requirements. If not, contact your prescribing physician for a new prescription / "written order" or to 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 Insurance-required documentation is included. If not, contact your physician to request the Insurance-required medical documentation.
   IMPORTANT - Medical documentation written on a prescription / "written order" is not accepted by Insurance companies. It must be written separately in your medical records and be part of your medical history from your prescribing physician.
   - ☐ Completed
5. Once complete, submit all of the following to ABC's DME department. It will be scanned and returned to you.
   - ☐ "Patient Instruction for Home Medical Equipment" form
   - ☐ "ABC Health Care Patient Information Record" form
   - ☐ Valid Prescription / Written Order
   - ☐ Equipment Documentation form with the accompanying Medical Records / Medical 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:____

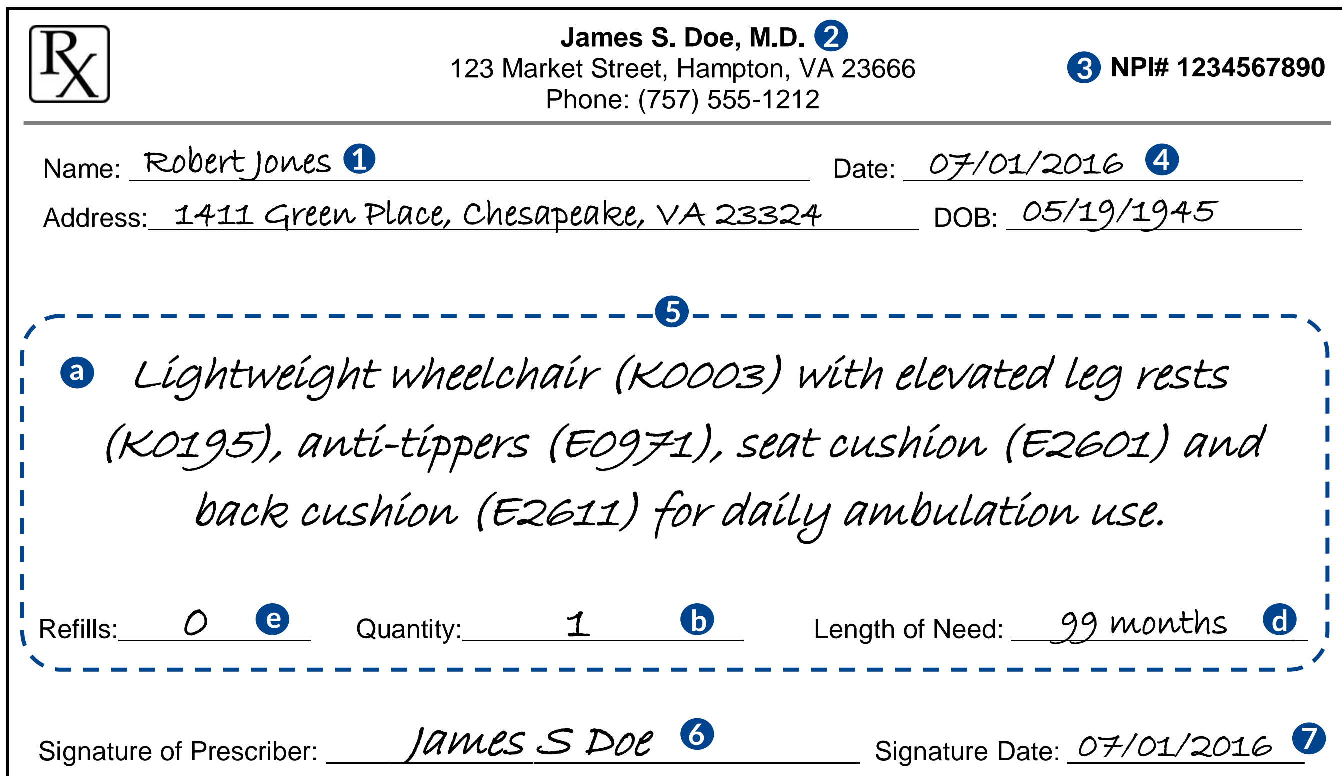
Relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐Other:____

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



Rx

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

❸ NPI# 1234567890

Name: Robert Jones ❶ Date: 07/01/2016 ❹

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

❺

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

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

Signature of Prescriber: James S Doe ❻ Signature Date: 07/01/2016 ❼

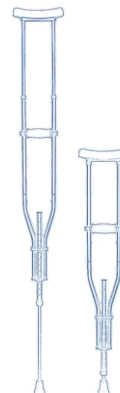
**IMPORTANT** – *Any / each change made to prescription that is already signed, **must** be initialed and dated by the physician to be accepted by Medicare*

Equipment Requirements & Check-Off List

• Crutches •

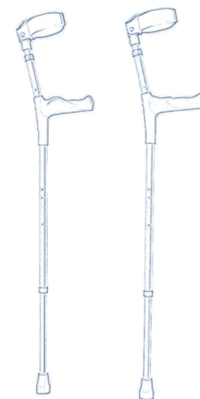
In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

Underarm Crutches



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0114 Underarm crutches"
  - ☐ 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 crutches, can only safely ambulate ____ feet (specify distance).
  - ☐ The functional mobility deficit can be sufficiently resolved by use of crutches.
  - ☐ Patient is willing and able to safely use the crutches for MRADL's in the home.

Forearm Crutches



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0110 Forearm crutches"
  - ☐ 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 crutches, can only safely ambulate ____ feet (specify distance).
  - ☐ The functional mobility deficit can be sufficiently resolved by use of crutches.
  - ☐ Patient is willing and able to safely use the crutches for MRADL's in the home.

ABC Health Care • 28 Research Drive, Hampton, VA 23666 • Phone: (757) 826-2600 • Fax: (757) 826-9269 • www.abc-hc.com

Knee Scooter (i.e. Knee Walker or Roll-A-Bout)

Medicare will not pay for knee scooters. If they are billed under the E0118 code, the claim will not be reimbursed because Medicare deems the device as "not reasonable and necessary". This is only available via cash payment. ABC carries knee walkers for both rent and/or sale. Pricing is available upon request.

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
A4635	REPLACEMENT ONLY - UNDERARM PAD, CRUTCH, EACH	Replacement only
A4636	REPLACEMENT ONLY, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH	Replacement only
A4637	REPLACEMENT ONLY, TIP, CRUTCH, EACH	Replacement only
E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS	Must meet criteria above
E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS	Must meet criteria above
E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	Must meet criteria above
E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP	Must meet criteria above
E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	Must meet criteria above
E0116	CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, WITH PAD, TIP, HANDGRIP, WITH OR WITHOUT SHOCK ABSORBER, EACH	Must meet criteria above
E0118	CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS, EACH	Medicare does not pay for these
E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	Must meet criteria for crutch

This document is not considered Medical Documentation or Medical Evidence. It provides guidance on what is required within the patient's Medical Records.