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

Example – TENS

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. Indicate whether this is for "initial trial period" or "trial successful"
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: 07/01/2016 (4)

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

(5)

(a) E0730 – TENS unit – 4 lead

(f) (c) Initial trial successful; use daily ongoing

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)

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

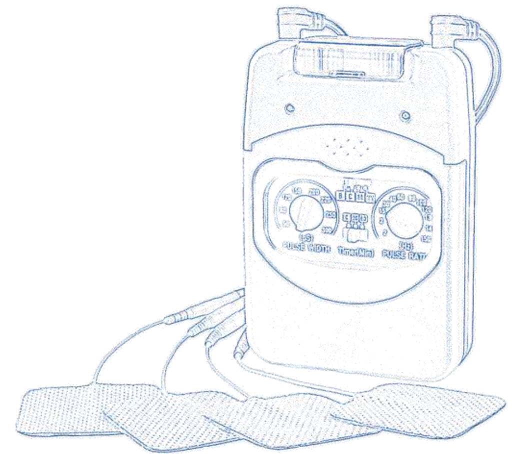
Equipment Requirements & Check-Off List

• TENS Units •

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.

Transcutaneous electrical nerve stimulation (TENS)

- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description of items and related accessories:
    - "E0730 – TENS unit - 4 lead"
  - ☐ Quantity = 1
  - ☐ Frequency = Daily
  - ☐ Duration / length of need must indicate if this order is for an initial use or ongoing use after an initial period:
    - If initial use, it must be trialed = "Initial trial of 2 months"
    - If initial use was successful = "Trial successful, length of needs is 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 within six months of the Written Order detailing ALL of the following:
  - ☐ Patient examination notes from physician must address the diagnosis and condition for which the TENS therapy is being prescribed.
  - ☐ Intractable chronic pain (not of the Lower Back) with etiology that presumably responds to TENS therapy.
    - NOTE – TENS therapy will not be considered medically necessary for:
      - Headaches
      - Visceral abdominal pain
      - Pelvic Pain
      - TMJ pain
      - Low Back Pain – Unless the patient is enrolled in an approved clinical study.
        - *Contact office for documentation requirements related to provision of TENS to participants of approved studies.*
  - ☐ Pain must have been present for at least 3 months
  - ☐ Other appropriate modalities (medication, therapy, etc) must have been tried and failed. No other treatment options are available for this patient.
  - ☐ The TENS therapy will help patient complete Activities of Daily Living (ADL).
  - ☐ Patient is willing and able to safely use the TENS therapy within the home.