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

**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)

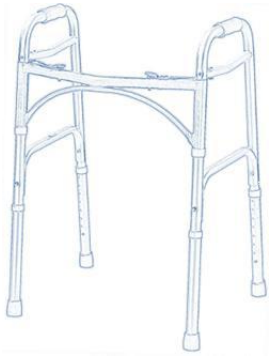
Signature of Prescriber: James S Doe (6) Signature Date: 07/01/2016 (7)

***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
## • Walkers •

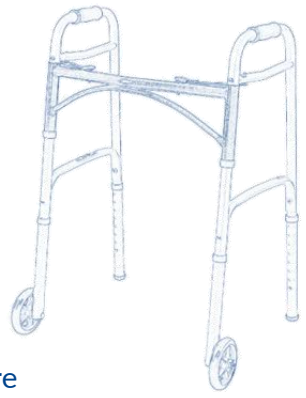
In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

## Walker – Folding (No Wheels):



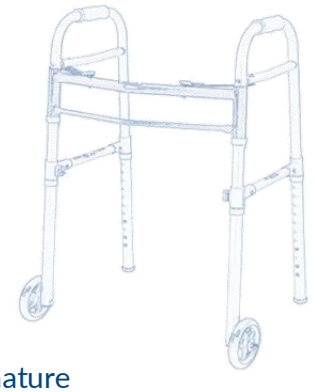
- o Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0135 Folding walker"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- o 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 walker, can only safely ambulate ____ feet (specify distance)
  - ☐ The functional mobility deficit is not corrected with a cane but can be sufficiently resolved by use of a walker.
  - ☐ Patient is willing and able to safely use the walker for MRADL's in the home.

## Walker – Folding with Front Wheels:



- o Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0143 Folding walker with wheels"
  - ☐ Quantity = 1
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- o 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 walker, can only safely ambulate ____ feet (specify distance)
  - ☐ The functional mobility deficit is not corrected with a cane but can be sufficiently resolved by use of a walker.
  - ☐ Patient is willing and able to safely use the walker for MRADL's in the home.

# Walker – Heavy Duty with Wheels



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "E0149 Heavy-duty folding" walker with wheels
  - ☐ 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 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 walker, can only safely ambulate ____ feet (specify distance)
  - ☐ The functional mobility deficit is not corrected with a cane but can be sufficiently resolved by use of a walker.
  - ☐ Patient is willing and able to safely use the walker for MRADL's 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 walker).

## 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 |
|---|---|---|
| E0135 | WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT | As defined above |
| E0140 | WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE | Must have documentation in medical record justifying the medical necessity for the special features |
| E0143 | WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT | As defined above |
| E0147 | WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE | Over 300lbs AND Unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand |
| E0148 | WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH | Patient must be over 300lbs |
| E0149 | WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE | Patient must be over 300lbs |
| E0154 | PLATFORM ATTACHMENT, WALKER, EACH | Allowed only if walker requirements met |
| E0155 | WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR | Allowed only if walker requirements met |
| E0156 | SEAT ATTACHMENT, WALKER | Allowed only if walker requirements met |
| E0157 | CRUTCH ATTACHMENT, WALKER, EACH | Allowed only if walker requirements met |
| E0158 | LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4) | Patient height must be 6ft or taller |
| E0159 | BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT ONLY, EACH | Allowed only if walker requirements met |