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)

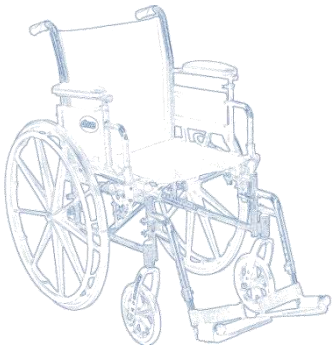
IMPORTANT – Any / each change made to prescription that is already signed, must be initialed and dated by the physician to be accepted by Medicare

Equipment Requirements & Check-Off List

• Manual Wheelchairs •

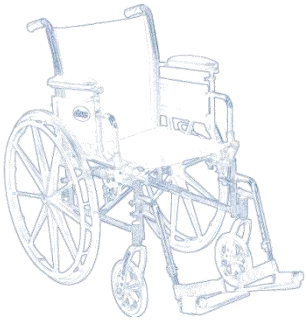
In order for ABC Health Care to complete the request for your prescribed home medical equipment, we will need the following documentation requirements completed in full and provided to our office in their entirety.

Standard Wheelchair



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "K0001 Standard Wheelchair" and include any additional accessories (listed at end of this document)
  - ☐ Quantity = 1
  - ☐ Frequency = Daily
  - ☐ 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 within six months of the Written Order detailing ALL of the following:
  - ☐ Patient examination notes from physician must address the condition for which the wheelchair is being prescribed.
  - ☐ Patient's diagnosis of "_____" creates mobility limitations that significantly impair the ability to participate in one or more Mobility Related Activities of Daily Living (toileting, feeding, grooming, dressing, bathing, etc.) in customary locations in the home.
  - ☐ Without the mobility assistive equipment, patient can only safely ambulate "_____" feet.
  - ☐ This mobility limitation cannot be resolved by the use of appropriately fitted cane or walker.
  - ☐ Use of manual wheelchair will significantly improve the patient's ability to participate in ADL's.
  - ☐ Patient has sufficient upper extremity function as well as physical and mental capacity to self-propel the manual wheelchair and/or has a caregiver willing and able to provide assistance with the wheelchair.
  - ☐ Patient's home environment has adequate space and can safely support the use of a manual wheelchair.
  - ☐ Patient is willing and able to safely use the manual wheelchair in the home.
  - ☐ Seat and back cushion ordered to improve seating tolerance and prevent skin breakdown.
  - ☐ Patient self-propels and needs the anti-tipper for safety with ramps

Lightweight Wheelchair



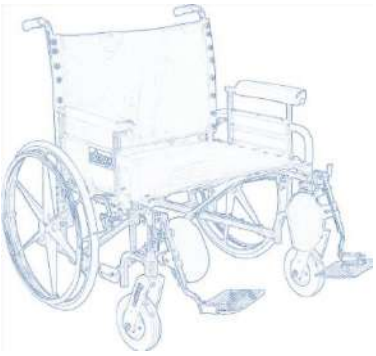
- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "K0003 Lightweight Wheelchair" and include any additional accessories (listed at end of this document)
  - ☐ Quantity = 1
  - ☐ Frequency = Daily
  - ☐ Duration / length of need = 99 months
  - ☐ Physician name
  - ☐ Physician signature
  - ☐ Physician signature date
  - ☐ NPI on prescription that matches ordering physician's signature
- Documentation within the medical chart from physician within six months of the Written Order detailing ALL of the following:
  - ☐ Patient examination notes from physician must address the condition for which the wheelchair is being prescribed.
  - ☐ Patient's diagnosis of "_____" creates mobility limitations that significantly impair the ability to participate in one or more Mobility Related Activities of Daily Living (toileting, feeding, grooming, dressing, bathing, etc.) in customary locations in the home.
  - ☐ Without the mobility assistive equipment, patient can only safely ambulate "_____" feet.
  - ☐ This mobility limitation cannot be resolved by the use of appropriately fitted cane or walker.
  - ☐ Use of wheelchair will significantly improve the patient's ability to participate in ADL's.
  - ☐ Patient is unable to self-propel in a standard wheelchair BUT patient has sufficient upper extremity function as well as physical and mental capacity to self-propel the lightweight wheelchair.
  - ☐ Patient's home environment has adequate space and can safely support the use of a wheelchair.
  - ☐ Patient is willing and able to safely use the wheelchair in the home.
  - ☐ Seat and back cushion ordered to improve seating tolerance and prevent skin breakdown.
  - ☐ Patient self-propels and needs the anti-tipper for safety with ramps

Heavy Duty Wheelchair

- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "K0006 Heavy Duty Wheelchair" and include any additional accessories (listed at end of this document)
  - ☐ Quantity = 1
  - ☐ Frequency = Daily
  - ☐ 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 within six months of the Written Order detailing ALL of the following:
  - ☐ Patient examination notes from physician must address the condition for which the wheelchair is being prescribed.
  - ☐ Patient's diagnosis of "_____" creates mobility limitations that significantly impair the ability to participate in one or more Mobility Related Activities of Daily Living (toileting, feeding, grooming, dressing, bathing, etc.) in customary locations in the home.
  - ☐ Without the mobility assistive equipment, patient can only safely ambulate "_____" feet.
  - ☐ This mobility limitation cannot be resolved by the use of appropriately fitted cane or walker.
  - ☐ Use of wheelchair will significantly improve the patient's ability to participate in ADL's.
  - ☐ Patient has sufficient upper extremity function as well as physical and mental capacity to self-propel the manual wheelchair and/or has a caregiver willing and able to provide assistance with the wheelchair.
  - ☐ Patient's home environment has adequate space and can safely support the use of a wheelchair.
  - ☐ Patient is willing and able to safely use the wheelchair in the home.
  - ☐ Seat and back cushion ordered to improve seating tolerance and prevent skin breakdown.
  - ☐ Patient self-propels and needs the anti-tipper for safety with ramps
  - ☐ Patient must have one or both of the following:
    - Patient weight was ____ pounds (enter weight; must be over 250 lbs but not more than 300lbs) on ____ (specify date; must be within one month of receipt of wheelchair).
    - Patient has severe spasticity

Extra Heavy Duty Wheelchair



- Detailed Written Order Requirements:
  - ☐ Patient name
  - ☐ Date of order
  - ☐ Detailed description = "K0007 Extra Heavy Duty Wheelchair" and include any additional accessories (listed at end of this document)
  - ☐ Quantity = 1
  - ☐ Frequency = Daily
  - ☐ 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 within six months of the Written Order detailing ALL of the following:
  - ☐ Patient examination notes from physician must address the condition for which the wheelchair is being prescribed.
  - ☐ Patient's diagnosis of "_____" creates mobility limitations that significantly impair the ability to participate in one or more Mobility Related Activities of Daily Living (toileting, feeding, grooming, dressing, bathing, etc.) in customary locations in the home.
  - ☐ Without the mobility assistive equipment, patient can only safely ambulate "_____" feet.
  - ☐ This mobility limitation cannot be resolved by the use of appropriately fitted cane or walker.
  - ☐ Use of wheelchair will significantly improve the patient's ability to participate in ADL's.
  - ☐ Patient has sufficient upper extremity function as well as physical and mental capacity to self-propel the manual wheelchair and/or has a caregiver willing and able to provide assistance with the wheelchair.
  - ☐ Patient's home environment has adequate space and can safely support the use of a wheelchair.
  - ☐ Patient is willing and able to safely use the wheelchair in the home.
  - ☐ Seat and back cushion ordered to improve seating tolerance and prevent skin breakdown.
  - ☐ Patient self-propels and needs the anti-tipper for safety with ramps
  - ☐ Patient weight was ____ pounds (enter weight; must be over 300lbs) on ____ (specify date; must be within one month of receipt of wheelchair).

Wheelchair Base Options

There are a wide variety of Wheelchair Bases available to match a patient's exact needs. Below are the options not shown in the earlier sections. To order, replace the code and item name in the "Detailed Description" section of the Detailed Written Order and provide the information in the documentation requirements (these are needed in conjunction with the documentation requirements shown in the Standard Wheelchair).

- K0002 Hemi Height Standard Wheelchair
  - ☐ Patient must have one or both of the following:
    - The patient requires a lower seat height (17" to 18") because of short stature.
    - The patient requires a lower seat height (17" to 18") to enable the patient to place feet on the ground for propulsion.

- K0004 High Strength, Lightweight Wheelchair
  - ☐ Patient must have one or both of the following:
    - The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
    - The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

- E1238 Pediatric Standard Wheelchair
  - ☐ Same as "Standard Wheelchair"

- Transport Chair
  - ☐ "E1038 Transport Chair Standard"
    - Include description of why patient is unable to make use of a standard wheelchair on their own
    - Include specific information that the patient has a caregiver who is willing and able to provide assistance with the transport chair
  - ☐ "E1039 Transport Chair HD"
    - Include description of why patient is unable to make use of a standard wheelchair on their own
    - Include specific information that the patient has a caregiver who is willing and able to provide assistance with the transport chair
    - Patient weight was ____ pounds (enter weight; must be over 300lbs) on ____ (specify date; must be within one month of receipt of wheelchair).
  - ☐ "E1037 Transport Chair Pediatric"
    - Include description of why patient is unable to make use of a standard wheelchair on their own
    - Include specific information that the patient has a caregiver who is willing and able to provide assistance with the transport chair

Wheelchair Accessories

There are a wide variety of accessories available to improve a patient's experience and safety while in their wheelchair. Below are some of the options not shown in the earlier sections. To order, replace or include the code and item name in the "Detailed Description" section of the Detailed Written Order and provide the information in the documentation requirements (these are needed in conjunction with the documentation requirements shown with any Wheelchair).

- E1226 Manual Fully Reclining Back
  - ☐ Patient must have one or both of the following:
    - The patient is at risk for development of pressure ulcer and is unable to perform a functional weight shift.
    - The patient uses intermittent catheterization for bladder management is unable to independently transfer from the wheelchair to the bed.
  - ☐ Also include the following items when ordering a "E1226 Manual Fully Reclining Back":
    - "K0195 Elevating Leg Rests"
    - "E0955 Headrest for Manual Wheelchair"

- K0195 Elevating Leg Rests - Pair
  - ☐ Patient must have at least one of the following:
    - The patient has a musculoskeletal condition or presence of a cast that prevents a 90 degree knee flexion.
    - The patient has significant edema of lower extremities that requires an elevating leg.
    - The patient is at risk for development of pressure ulcer and is unable to perform a functional weight shift.
    - The patient uses intermittent catheterization for bladder management is unable to independently transfer from the wheelchair to the bed.
    - The patient has a fully reclining back on the wheelchair.

- E0955 Headrest for Manual Wheelchair
  - ☐ The patient has a fully reclining back on the wheelchair.

- E0951 Heel Loops
  - ☐ Patient needs heel loops to (one of the following):
    - Maintain their feet safely on the footplates due to (one of the following):
      - Spasticity
      - Paralysis
      - Another physical condition
    - Prevent injury by feet being caught in front casters.
    - Maintain proper lower extremity alignment while using the wheelchair.

- E0961 Brake Extensions
  - ☐ The patient is unable to independently operate wheel locks due to (one of the following):
    - Upper extremity weakness
    - Decreased range of motion
    - Muscle spasticity
    - Hemiplegia

- E0978 Seat Belt
  - ☐ Patient must have at least one of the following:
    - The patient has weak upper body muscles which require use of the seat belt for proper positioning.
    - The patient has weak upper body instability which requires use of the seat belt for proper positioning.
    - The patient has muscle spasticity which requires use of the seat belt for proper positioning.

- E0973 Adjustable Arms
  - ☐ The patient requires an arm height that is different than what are available using standard or non-adjustable arms.
  - ☐ The patient spends at least 2 hours per day in the wheelchair.

- E2209 Arm Trough
  - ☐ The patient has (must have at least one of the following conditions):
    - Quadriplegia
    - Hemiplegia
    - Uncontrolled movements.

- E0950 Tray
  - ☐ The patient cannot participate in one or more Mobility Related Activities of Daily Living without the use of a wheelchair tray.
  - ☐ The patient spends at least 2 hours per day in the wheelchair.

- E2208 Oxygen Cylinder Holder
  - ☐ The patient is also currently using home oxygen therapy within the home.
  - ☐ The patient cannot safely ambulate in the wheelchair while using home oxygen therapy without the use of the oxygen cylinder holder.

Manual Wheelchair Cushions

- "Skin Protection" Cushions:
  - ☐ "E2603 Skin Protection Seat Cushion – Standard" (less than 22" in width)
  - ☐ "E2604 Skin Protection Seat Cushion – Standard" (22" in width or greater)
  - ☐ "E2622 Skin Protection Seat Cushion – Adjustable" (less than 22" in width)
  - ☐ "E2623 Skin Protection Seat Cushion – Adjustable" (22" in width or greater)
  - ☐ Qualifications for all of the above:
    - The patient has at one or both of the following conditions:
      - Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface
      - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses:
        - Spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease, muscular dystrophy, hemiplegia, Huntington's chorea, idiopathic torsion dystonia, athetoid cerebral palsy, arthrogryposis, osteogenesis imperfecta, spinocerebellar disease or transverse myelitis

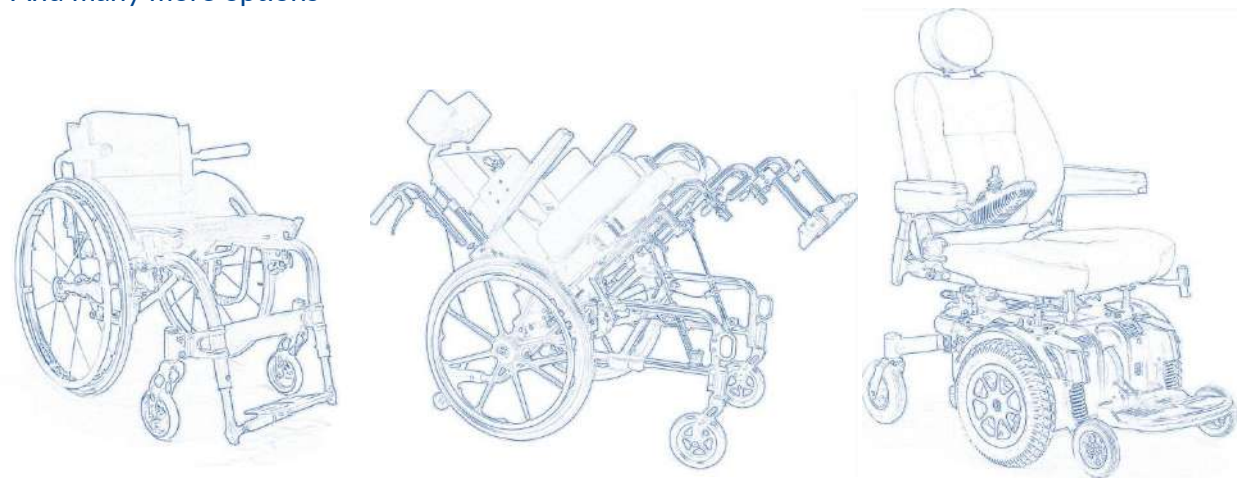
- "Positioning" Cushions:
  - ☐ "E2605 Positioning Seat Cushion" (less than 22" in width)
  - ☐ "E2606 Positioning Seat Cushion" (22" in width or greater)
  - ☐ "E2613 Positioning Back Cushion" (less than 22" in width)
  - ☐ "E2614 Positioning Back Cushion" (22" in width or greater)
  - ☐ Qualifications for all of the above:
    - The patient has at least one significant postural asymmetry due to monoplegia of the lower limb due to stroke, traumatic brain injury, or other etiology, spinocerebellar disease, above knee leg amputation, osteogenesis imperfecta, transverse myelitis Spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease, muscular dystrophy, hemiplegia, Huntington's chorea, idiopathic torsion dystonia, athetoid cerebral palsy, arthrogryposis, osteogenesis imperfecta, spinocerebellar disease or transverse myelitis

- Combination "Skin Protection" & "Positioning" Cushions:
  - ☐ "E2607 Skin Protection & Positioning Seat Cushion – Standard" (less than 22" in width)
  - ☐ "E2608 Skin Protection & Positioning Seat Cushion – Standard" (22" in width or greater)
  - ☐ "E2624 Skin Protection & Positioning Seat Cushion – Adjustable" (less than 22" in width)
  - ☐ "E2625 Skin Protection & Positioning Seat Cushion – Adjustable" (22" in width or greater)
  - ☐ To qualify for any of the above, the patient must meet the qualifications for BOTH the "Skin Protection" and "Positioning" cushion.

Custom, Rehab, & Power Wheelchairs

ABC Health Care offers a wide variety of custom, rehab, and power wheelchair options. To inquire about custom, rehab, or power mobility equipment for your patient, please contact our Power Wheelchair department at your local ABC Health Care service center. Services include both purchases and rentals. Chair options include:

- Ultra-Lightweight Wheelchairs
- Manual Tilt n Space Wheelchairs
- Scooters
- Travel Mobility devices
- Power Chairs
- Complex rehabilitation devices
- Seating & Positioning
- Single & multi motor
- Lifts and iLevel
- Complex drive systems (electronic head array, "Puffer", etc.)
- Custom cushions & support
- And many more options



Our team of RESNA-certified Assistive Technology Practitioners (ATP) is standing by to assist you and your patients