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Physician Order Form

PLEASE INCLUDE SUPPORTING MEDICAL DOCUMENTATION AND DEMOGRAPHICS

PRACTICE NAME: _____ **ITEM ID**: _____ **SERIAL #:** _____

PATIENT INFORMATION: _____
(First Name) (M.I.) (Last Name)

__/__/__ M / F _____
(Date of Birth) (Gender) (Address)

_____
(City) (State) (Zip) (Contact Phone)

GUARANTOR INSURANCE: _____
(First Name) (M.I.) (Last Name)

__/__/__ M / F _____
(Date of Birth) (Gender) (Relationship) (Address)

_____
(City) (State) (Zip) (Contact Phone)

PRIMARY INSURANCE COMPANY: _____ MEMBER ID#: _____ GROUP ID#: _____

SECONDARY INSURANCE COMPANY: _____ MEMBER ID#: _____ GROUP ID#: _____

PLEASE PROVIDE A COPY OF INSURANCE CARDS (FRONT & BACK)

NEW CUSTOMER / INITIAL EQUIPMENT SET-UP ACTIONS COMPLETED

[] Physician's prescription reviewed [] Equipment education completed / Written materials provided
[] New patient packet / HIPAA Privacy Notice provided []Assessment / Plan of care completed (if applicable)

Instructions completed by: _____ Date: __/__/__ Time: _____

CERTIFICATE OF MEDICAL NECESSITY:

Start of Care Date: _____/_____/_____

Length of Need (in months): _____ 99 = lifetime

DIAGNOSIS:

- ☐ Asthma/RAD (J45.909)
- ☐ COPD (J44.9)
- ☐ Chronic Bronchitis (J42)
- ☐ Bronchiolitis (J21.0)
- ☐ RSV (B97.4)
- ☐ Pneumonia (J18.9)
- ☐ Croup (J05.0)
- ☐ Acute Bronchitis (J20.9)
- ☐ Trachemalacia/HAD (J39.8)
- ☐ URI (J39.9)
- ☐ Wheezing (R06.2)
- ☐ Other (please list ICD 10 code)

_____ _____ _____

PRESCRIPTION:

- ☐ Nebulizer Compressor (E0570)
- ☐ Reusable Aerosol Kit (A7005)
- ☐ Disp.Aerosol Kit (A7003)
- ☐ Mask (A7015)
- ☐ Peak Flow Meter
- Ĭ Vented Holding Chamber (Spacer) (A4627)
- ☐ Disposable Filter (A7013)
- Ĭ Other _____

PLEASE LIST MEDICATION/FREQUENCY/DOSAGE: _____

(FOR INSURANCE PURPOSES ONLY – MEDOVILLE DOES NOT SUPPLY MEDICATION)

I certify that the above services are required, medically necessary and authorized by me. This patient is under my care, and is in need of the services specified herein. This document may serve as written confirmation of a verbal order, and the information above is contained in the patient's medical record.

PHYSICIAN SIGNATURE: _____ **PHYSICIAN NAME PRINTED**: _____

NPI #: _____ **SIGNATURE DATE:** __/__/__

TERMS AND CONDITIONS: I, the undersigned, have read, understand, and accept the terms and conditions on the back of this form. They include; DMEPOS Supplier Standards, Request for Provision of Services, Patient Bill of Rights, Release Information, Assignment of Benefits, Agreement to Pay and Release of Liability. **Please note that the patient is financially responsible for deductible, coinsurance, and any other out of pocket expense, including denial of claim.**

PATIENT OR GUARANTOR SIGNATURE _____ **RELATIONSHIP** **DATE**

☐ I consent to receiving information about my financial responsibility (if any) via eDelivery. My email address where I would like to receive correspondence: _____

White Copy: Fax to Medoville/Binder Yellow Copy: Patient

DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business, with visible signage. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date - October 1, 2009*
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date- May 4, 2009*
27. A supplier must obtain oxygen from a state- licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

REQUEST FOR PROVISION OF SERVICES

I understand that by signing this agreement, I indicate my wish to purchase health care products or service or both from Medoville Inc.

PATIENTS BILL OF RIGHTS

You have the right to:

- Service that is considerate and respectful of your person, property, dignity and individuality.
- Obtain appropriate care/services regardless of race, creed, national origin, sex, age, disability, illness, religious affiliation, economic status or source of payment and in accordance with physician orders.
- Be advised of policies and procedures regarding the disclosure of clinical records.
- Confidentiality of all information pertaining to you, your medical care and service.
- A timely response to your request for service and to expect continuity of services.
- Select the home medical equipment supplier of your choice.
- Be fully informed in advance about service to be provided, disciplines that furnish care, frequency of visits and any modifications to the plan of care.
- Make informed decisions regarding, and participate in, your care planning.
- Be informed of provider service/care limitations.
- Be told what service will be provided in your home, how often and by whom and be able to identify visiting staff members through proper identification.
- Be informed, both verbally and in writing, in advance of services being provided, payment expected from third parties, and an estimate of charges for which you will be responsible.
- Agree to or refuse any part of the plan of service, care or treatment after the consequences of refusing services/care or treatment are fully presented.
- Be informed of the grievance procedure and voice grievances of any kind, or recommend changes in policies or staff, without fear of termination of service or other reprisals.
- Have grievances/complaints regarding care furnished, care not furnished or failure to respect person or property fully investigated.
- Be informed of any financial benefits to our company, when referred to another organization.
- Have your communication needs met.

You have the responsibility to:

- Ask questions about any part of the plan of service or plan of care that you do not understand.
- Protect the equipment from fire, water, theft or other damage while it is in your possession.
- Use the equipment for the purpose for which it was prescribed, following instructions provided for use, handling care, safety and cleaning.
- Supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered by insurance. You are responsible for settlement in full of your account.
- Be at home for scheduled service visits or notify us in advance to make other arrangements.
- Notify us immediately of:
- Equipment failure, damage or need of supplies.
- Any change in your prescription or physician.
- Any change or loss in insurance coverage.
- Any change of address or telephone number, whether permanent or temporary.
- Discontinued equipment or services.
- Be respectful of the property owned by our company and considerate of our personnel.
- Contact us if you acquire an infectious disease during the time we provide services.

RELEASE OF INFORMATION

I authorize my insurer(s), and any other third party payor who provides me with coverage, to disclose to Medoville Inc. any information regarding such coverage, including, but not limited to, payments made by such insurer(s) or third party payor(s) to me, for home healthcare products or services rendered to me by Medoville Inc., and the scope and extent of coverage available from time to time. I authorize all medical personnel to provide information to Medoville Inc. concerning my medical history as it may relate to my home services and health care product needs. If my primary insurance changes, I agree to notify Medoville Inc.

ASSIGNMENT OF BENEFITS

I authorize Medoville Inc. to request on my behalf, and to collect directly, all public and private insurance coverage benefits due for products and services supplied by authorize Medoville Inc. In the event payments for insurance benefits are made directly to me, the payee, I will endorse all checks for payment to Medoville Inc. I accept all responsibility for overpayments per statement.

AGREEMENT TO PAY

Our mission at Medoville Inc. is to offer our clients outstanding service and simplify the way that medical supplies are ordered and received. Medoville Inc. manages all of the requirements associated with ordering supplies under Medicare, Medicaid and other insurance plans for clients, such as obtaining prescriptions, letters of medical necessity and insurance prior approvals, if required. Our client service representatives help clients determine their insurance coverage and bill the insurance(s) on their behalf. The client agrees and accepts all responsibility to pay Medoville Inc. the balance due not covered by the insurance or any other payer.

RELEASE OF LIABILITY

I hereby release my clinician of any liability relating to the purchase/rental of this product/service. I understand that this equipment is the property of Medoville Inc.

I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or other medical insurance is correct.

1. The patient, if physically and mentally competent, must sign on his/her behalf. If he/she cannot sign for himself/herself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian, may sign. The source of the signatoree's authority should be stated (e.g. "Social Security appointed Representative Payee," or "court appointed guardian," etc.).
2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 (I-84) and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself/herself to release to the Social Security Administration or its intermediaries or carrier any information needed to process related Medicare claims. He/she further permits a copy of the authorization to be used in place of original.
3. On assigned claims, the provider agrees to accept the Medicare carriers' allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and customer at any time by written notice to the Medicare Center.

I request payment under the Medical Insurance Part of MEDICARE/Medicaid/Private Insurance be made directly Medoville Inc. for service furnished me during the effective period of this authorization. I have read and I agree to the release of information as specified in Paragraph 2 above.