AuBurn Pharmacy

DME Intake Form and Delivery Instruction Ticket

Patient Information

Name: DOB: Gender: ____M ____F

Address: City/State/Zip:

Phone: SSN#

Primary Health Insurance Coverage	**Supplemental/ Secondary Insurance Coverage**
Insurance Company:	**Insurance Company:**
Is this a Medicare HMO or Advantage Plan? Y N Insurance ID #:	**Is this a Medicare HMO or Advantage Plan? Y N** Insurance ID #:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

Home Environment/Safety Assessment **___ Not Applicable - Not Delivered to Home**

Discuss all appropriate Factors and check if in order

___ Safety

Uncluttered Pathways	Fire safety assessed
Safe operating equip	Cords & Adapters
Safe Envrionemnt	Pt/CG understands safety issues
Bathroom Assessed	Safe electrical outlet
Area Rugs	Getting in & out of device

Appropriate for Home

___ Yes ____NO
___ Alert & Understands INSTRUCTIONS
___ Return Demonstration by patient
___ Pt. Confused / Caregiver instructed

Note any Personal / Physical limits:

___ Patient understands use of diabetci tesing meter
___ DME item was checked and in good working order
(Confirm supplies have not expired)

Physician Information	**Equipment Information**
Name:	Equipment/ Product:
Address:	Manufacturer: Model:
City/State/Zip:	Serial# :
Phone:	Purchase: Rental:
NPI:	Quantity Dispensed:
Referring MD State License Verified _____________**(Date)**	Pt Height: Pt weight:
Pecos Enrollment Verified _____________**(Date)**	Diagnosis: ICD-10 Code(s):

Supplier information for File Check All

____ Complete Written order
____ Assignment of Benefits (signed)
____ Copy of Medicare card
____ Copy of Supplemental or Secondary Card
____ ABN (Only if appropriate)
____ Medical record documentation if required **(Walkers/Diabetic Shoes)**
____ IVR Called for Same or Similar **(Walkers/Canes/ Glucometer/Nebulizer/Wheelchairs)**
____ DME Inspection Repair form completed **(Walker/ Canes/Glucometer/Nebulizer/Wheelchairs)**
____ Capped Rental form signed **(Walkers/Canes/ Glucometer/Nebulizer/Wheelchairs)**
____ Patient Satisfaction Survey Completed
____ Nebulizer/Med Follow-up Completed
____ New Diabetic Testing Follow-up completed
____ Diabetic Shoe Follow-up Completed

Patient Information: (Check if Pt received all)

___ Copy of Supplier Standards (I have received)
___ Patients Rights & Responsibilities (I have received)
___ Notice of Privacy Practices (I have received)
___ I have received the equipment as prescribed by physician
___ Equipment has been properly fitted to me and meets my needs. (I have received)
___ As the recipient, the guardian of the recipient, and or the primary caregiver of the recipient, I have received training and or instruction regarding the equipment's proper use and maintenance.
___ I have received a copy of the AuBurn Pharmacy's complaint protocol.
___ I have been given the opportunity to rent or purchase inexpensive or routinely purchased DME and or capped rental equipment.
___ I have been instructed & understand the warranty coverage on the product that I have received.

____ _________________________

Signature Patient / Authorized Representative **Date**

If Patient cannont sign, the following MUST be filled out:

____ _________________________ _________________________

Authorized Representative Printed Name **Relationship** **Why Patient cannot sign**

Provider Representative Signature ______________________________________ Date ______________________

Revised 01/01/2017 ARS