AuBurn Pharmacy Assignment of Benefits

This form is required to bill on your behalf!

Patient Name ______________________________ **DOB** ________________

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to AuBurn Pharmacy and/or any of our corporate affiliates for medical supplies and/or medication(s) furnished to me by AuBurn Pharmacy.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. AuBurn Pharmacy and/or any of our corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. AuBurn Pharmacy and/or any of our corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

___________________________________ ____________________

Signature of Patient / Authorized Representative **Date**

If patient cannot sign, the following **MUST** be filled out:

Authorized Representative Printed Name _________________________________

Relationship ____________________________ Contact Number ________________

Why Patient cannot sign ____

Auburn Pharmacy, Inc.
259 W. Park Road
Garnett, KS 66039
785-448-3600

Application for Medicare Co-Insurance Waiver

MEDICARE LAW REQUIRES A HEALTH CARE PROVIDER (SUCH AS A PHARMACY OR MEDICAL EQUIPMENT COMPANY) THAT ACCEPTS AN ASSIGNMENT FOR SERVICES BILLED TO THE MEDICARE PROGRAM, TO BILL THE BENEFICIARY FOR A PORTION OF THE COST OF THESE SERVICES. THIS IS CALLED MEDICARE CO-INSURANCE. THE HEALTH CARE PROVIDER MAY, HOWEVER, ELECT TO WAIVE ALL OR A PORTION OF THE MEDICARE CO-INSURANCE IF THE HEALTH CARE PROVIDER DETERMINES THAT THE BENEFICIARY DOES NOT HAVE THE ABILITY TO PAY THE MEDICARE CO- INSURANCE. IN ORDER TO ASSIST US IN DETERMINING IF YOU HAVE THE ABILITY TO PAY THE MEDICARE CO-INSURANCE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

NAME: ______________________ PHONE NUMBER: ______________________

ADDRESS: ______________________ DATE OF BIRTH: ____/____/______ SEX: _____

______________________ MEDICARE # ______________________

1) ARE YOU RECEIVING ANY TYPE OF ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, DESCRIBE THIS ASSISTANCE: ______________________

____

2) IF NOT, DO YOU QUALIFY FOR ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, WHAT TYPE OF ASSISTANCE ARE YOU QUALIFIED TO RECEIVE? ______________________

____

3) DO YOU HAVE OTHER HEALTH INSURANCE THAT COVERS HEALTH RELATED PRODUCTS OR SERVICES? YES ☐ NO ☐
IF "YES", LIST THE COMPANIES AND POLICY NUMBERS:

____

____

4) IS A GUARDIAN OR ANYONE ELSE LEGALLY RESPONSIBLE FOR YOUR MEDICAL BILLS? YES ☐ NO ☐
IF "YES", GIVE THE NAME, ADDRESS AND PHONE NUMBER OF THIS PERSON:

____

____

5) ARE YOU EMPLOYED? YES ☐ NO IF "YES", WHAT IS YOUR PAY PERIOD
(E.G., WEEKLY, EVERY OTHER WEEK, 1ST & 15TH)? ______________________
HOW MUCH DO YOU GROSS PER PAY PERIOD? ______________________
HOW MUCH DO YOU NET PER PAY PERIOD? ______________________

6) DO YOU OWN YOUR OWN HOME? YES ☐ NO ☐
IF "YES", IS IT PAID FOR OR ARE YOU STILL MAKING PAYMENTS ON IT? YES ☐ NO ☐
HOW MUCH IS EACH MONTHLY PAYMENT? ______________________

7) HOW MUCH DO YOU HAVE IN SAVINGS TO WHICH YOU HAVE IMMEDIATE ACCESS?
(DOES NOT INCLUDE QUALIFIED RETIREMENT) ______________________

8) WHAT IS YOUR MONTHLY NET INCOME FROM:

YOUR EMPLOYMENT:______________________________

SOCIAL SECURITY: ______________________________

RETIREMENT: ______________________________

INVESTMENTS: ______________________________

OTHER: ______________________________

TOTAL MONTHLY Income: $______________________

9) WHAT ARE YOUR MONTHLY EXPENSES:

RENT OR HOUSE PAYMENT:______________________________

UTILITIES:______________________________

CAR PAYMENT: ______________________________

OTHER TRANSPORTATION: ______________________________

FOOD:______________________________

MEDICAL BILLS:______________________________

OTHER:______________________________

TOTAL MONTHLY EXPENSES: $______________________

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I REQUEST THAT THE MEDICARE CO-INSURANCE BE WAIVED. I ALSO UNDERSTAND THAT THIS IS AN APPLICATION AND THAT I AM RESPONSIBLE FOR ANY AND ALL PAYMENTS UNLESS I RECEIVE AN APPROVAL IN WRITING.

______________________________ ______/______/______

BENEFICIARY SIGNATURE DATE

______________________________ ______________________

SIGNATURE IF BENEFICIARY UNABLE TO SIGN RELATIONSHIP TO BENEFICIARY

____

REASON BENEFICIARY UNABLE TO SIGN

☐

☐

FOR OFFICE USE ONLY

DATE:____/____/____ WAIVER APPROVED ☐ WAIVER DENIED ☐

APPROVAL SIGNATURE: ______________________________

TITLE: ______________________ DATE:______/______/______

A. Notifier: ________________

B. Patient Name: ________________________ **C. Identification Number:** ________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ______________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ______________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ______________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ______________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ______________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. **If you have other questions on this notice or Medicare billing, call** 1-800-MEDICARE **(1-800-633-4227/**TTY: **1-877-486-2048).**
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Print Form

Enrollee's Name:______________________________________(Optional)

Drug and Prescription Number:__________________________________(Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Nombre del beneficiario: ________________________________ (opcional)

Número de receta y de medicamento: ______________________ (opcional)

La cobertura de Medicare de las recetas médicas y sus derechos

Sus derechos si tiene Medicare

Usted **tiene el derecho de solicitar una determinación de cobertura** de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene **el derecho de solicitar una determinación de cobertura especial conocida como "excepción"** si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como "formulario".
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido.

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

Si desea más información, consulte los materiales del plan o llame al 1-800-MEDICARE.

Declaración sobre la Ley para la Reducción de Trámites De acuerdo con la Ley para la Reducción de Trámites de 1995 (PRA en inglés), las personas no están obligadas a responder una recopilación de información a menos que se exhiba un número de control de la oficina de Gerencia y Presupuesto (OMB en inglés) válido. El número de control OMB válido para esta recopilación de información es 0938-0829. El tiempo necesario para responder esta recopilación de información es de aproximadamente 10 minutos por respuesta, incluido el tiempo para revisar instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, llame al 1-800-MEDICARE o envíe un correo electrónico a: AltFormat@cms.hhs.gov.

Commonly Used HCPCS

E0607 NU KX—GLUCOSE MONITOR (ONE EVERY TWO YEARS **FOR KS MEDICAID**) **EVERY 5 YEARS MEDICARE!!!!!**

A4250 KX-- KETOSTIX URINE TEST STRIP (100=1 UNIT)

A4252 KX—KEYTONE BLOOD GLUCOSE TEST STRIPS (100=1UNIT)

A4258 KX -- LANCING DEVICE

A4253 NU KS or KX---TEST STRIPS (50 STRPS = 1 UNIT) **(MUST BILL UNITS)**

A4259 KS or KX---LANCETS (100 LANCETS = 1 UNIT) **(MUST BILL UNITS)**

E0570 NU---NEBULIZER (ONE EVERY 3 YEARS FOR KS **MEDICAID**) **EVERY 5 YEARS FOR MEDICARE!!!!!**

A4614, S8096---PEAK FLOW METER (EVERY 180 DAYS)

S8100, S8101---HOLDING CHAMBERS, W OR W/O MASK (EVERY 90 DAYS)

V5266---HEARING AID BATTERY

A4215 KX---NEEDLES (1NEEDLE= 1 UNIT) **(MUST BILL UNITS)**

S8490---SYRINGES (100 SYRINGES = I UNIT) **(MUST BILL UNITS)**

A4206---SYRINGE WITH NEEDLE 1CC (1NEEDLE= 1 UNIT) **(MUST BILL UNITS)**

A4565---SLING

A4570---SPLINT

S8451---SPLINT, PREFABRICATED WRIST OR ANKLE

A4490---SURGICAL STOCKING ABOVE KNEE 1= I UNIT

A4495---SURGICAL STOCKING THIGH LENGTH 1= 1 UNIT

A4500---SURGICAL STOCKING BELOW KNEE 1= 1 UNIT

A4510---SURGICAL STOCKING FULL LENGTH 1= 1 UNIT

A6196---AQUACEL HYDROFIBER DRESSING 10 UNITS

A6235---DUODERM 6X6 DRESSING =10 UNITS

A4554---DISPOSABLE PADS (50 PADS =1 UNIT) CHUXS

A5631—COMPRESSION STOCKINGS 30-40MMHG

A4256---CONTROL SOLUTION (GLUCOMETER)

E0105---QUAD CANE

L3908---WRIST BRACE-SPLINT

L1810—KNEE BRACE W/HINGE

E0114—ALUMINUM CRUTCHES

A4230 –INSULIN PUMP SETS (1 EA = 1 UNIT)

K0552 INSULIN RESEVOIR (1 EA = 1 UNIT)

A6250 – SKIN PREP WIPES (50 WIPES = 1 UNIT)

**E0143 NU KX -- WALKER W/WHEELS FOLDING

E0156 NU KX -- WALKER SEAT ATTACHMENT **(KS MEDICAID DOES NOT PAY FOR THE SEAT)

E0603 NU – ELECTRONIC BREAST PUMP (SINGLE OR DOUBLE PUMP)

MEDICARE COVERED ITEM ONLY

A4235—BATTERIES FOR GLUCOMETER

MODIFIERS

NU-(MUST BE USED WITH DIABETIC STRIPS)

KS -NIDDM

KX- IDDM

RR- RENTAL CAPPED EQUIPMENT

GA- Provider believes Medicare may not pay for service