Patient Name: _____ Date: _____

Check -off Sheet for DME to determine Pt Eligibility and Pt Liability (Walker/Rollator/Canes/Diabetic Shoes/Nebulizer/Glucometer/Etc.)

Please follow the check list below to determine Pt Eligibility

- ☐ ***Complete Written /faxed order with diagnosis code.***
- ☐ ***Beneficiary's Zip Code is in the Competitive BID area. www.dmecompetitivebid.com Zip Code: _____***
- ☐ ***Medicare IVR System checked to make sure a same or similar item has not been billed. (1-877-320-0390)***
  Information you will need to call the IVR Line: (Diabetic shoes can billed once every year if eligible) (ALL other DME is every ***5*** Years)
  - *NPI: ____ _____*
  - *PTAN: _____*
  - *Last 5 Digits of TIN: _____*
  - *Pt. Medicare # _____*
  - *Patient Name and DOB: _____*
  - *HCPCS: _____ Modifier: _____*

Please follow the check list below to determine pt. Liability

- ☐ **Copy of Medicare Card and or Copy of *Advantage Plan (front and back)* *Please follow check list below.***
- ☐ **Copy of Medicare supplemental card (front and back) *Please follow check list below.***
- ☐ **Is our Pharmacy in the Beneficiary's Plan Network, if not does this Beneficiary have out of network coverage.**
- ☐ **Does this item/HCPCS require a PA?**
- ☐ **Is this HCPCS a covered service for this Beneficiary's Plan?**
- ☐ **If a covered service, has the Pts Medicare/ Advantage Plan deductible been met, if not met does this plan pick up the Medicare/ Advantage Plan deductible.**
- ☐ **If Advantage Plan and billing Diabetic strips, you will need to find out what strips and lancets are on the Beneficiary's formulary and bill them on the prescription side and not through Major Medical.**
- ☐ **If this is an Advantage Plan, what will the Pt. co-pay be?**

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Order Product *ONLY* after we have received Medical Record Documentation to support the need for the Product that was ordered by the Physician.

Order Product *ONLY* after all of these questions have been answered and the Pt. is aware up front what any out of pocket expense will be.

- ☐ **ABN completed and explained to patient (only complete ABN if indicated).**
- ☐ **Bill Medicare or Advantage Plan.**
- ☐ **Copy of Product page scanned in documents section with:**
  - Serial Number and Lot Number
  - Noted in Rx notes for Amanda
  - Copy in Folder
- ☐ **Have pharmacist check RX and Product.**
- ☐ **Ring out through register and get signature**
- ☐ **Patient Satisfaction Survey Completed at least 72 hours after patient receives product.**