

AuBurn Pharmacy

DME Intake Form and Delivery Instruction Ticket

+ Copies of all insurance cards
+ Copy of DME prescription

Patient Information	
Name: _____	DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> 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	Is this a Medicare HMO or Advantage Plan? Y N
Insurance ID #: _____	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 Environment Pt/CG understands safety issues Bathroom Assessed Safe electrical outlet Area Rugs Getting in & out of device	Appropriate for Home <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Alert & Understands INSTRUCTIONS <input type="checkbox"/> Return Demonstration by patient <input type="checkbox"/> Pt. Confused / Caregiver instructed Note any Personal / Physical limits: <input type="checkbox"/> Patient understands use of diabetic testing meter <input type="checkbox"/> 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	Patient Information: (Check if Pt received all)
<input type="checkbox"/> Complete Written order <input type="checkbox"/> Assignment of Benefits (signed) <input type="checkbox"/> Copy of Medicare card <input type="checkbox"/> Copy of Supplemental or Secondary Card <input type="checkbox"/> ABN (Only if appropriate) <input type="checkbox"/> Medical record documentation if required (Walkers/Diabetic Shoes) <input type="checkbox"/> IVR Called for Same or Similar (Walkers/Canes/Glucometer/Nebulizer/Wheelchairs) <input type="checkbox"/> DME Inspection Repair form completed (Walker/Canes/Glucometer/Nebulizer/Wheelchairs) <input type="checkbox"/> Capped Rental form signed (Walkers/Canes/Glucometer/Nebulizer/Wheelchairs) <input type="checkbox"/> Patient Satisfaction Survey Completed <input type="checkbox"/> Nebulizer/Med Follow-up Completed <input type="checkbox"/> New Diabetic Testing Follow-up completed <input type="checkbox"/> Diabetic Shoe Follow-up Completed	<input type="checkbox"/> Copy of Supplier Standards (I have received) <input type="checkbox"/> Patients Rights & Responsibilities (I have received) <input type="checkbox"/> Notice of Privacy Practices (I have received) <input type="checkbox"/> I have received the equipment as prescribed by physician <input type="checkbox"/> Equipment has been properly fitted to me and meets my needs. (I have received) <input type="checkbox"/> 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. <input type="checkbox"/> I have received a copy of the AuBurn Pharmacy's complaint protocol. <input type="checkbox"/> I have been given the opportunity to rent or purchase inexpensive or routinely purchased DME and or capped rental equipment. <input type="checkbox"/> I have been instructed & understand the warranty coverage on the product that I have received.

Signature Patient / Authorized Representative _____ Date _____

If Patient cannot sign, the following MUST be filled out:

Authorized Representative Printed Name	Relationship	Why Patient cannot sign
Provider Representative Signature	Date	