



## **Patient Packet- Diabetic Shoes and Inserts**

Contents:

1. Medicare required information
  - Medicare Supplier Standards
  - HIPPA Notice
  - Equipment Warranty Information
  - Complaint Protocol for Medicare Beneficiaries
  - Patient Rights and Responsibilities
2. AuBurn Pharmacy DME Intake Form
3. Assignment of Benefits Form
4. Medicare Rental/purchase Agreement Form



## Diabetic Shoe Break-in Information

- For the first 5 days only wear your shoes inside, preferably on carpet until you decide to keep them.
- During the trial period, examine your feet before wearing your shoes, looking for red spots.
- After wearing your shoes examine your feet again for any new red spots or irritated areas.

- Day 1: Wear shoes for one hour      Date: \_\_\_\_\_
- Day 2: Wear shoes for two hours      Date: \_\_\_\_\_
- Day 3: Wear shoes for three hours      Date: \_\_\_\_\_
- Day 4: Wear shoes for four hours      Date: \_\_\_\_\_
- Day 5: Wear shoes for five hours      Date: \_\_\_\_\_

How long to wear shoes following the break-in period is at your discretion. It is highly recommended that break-in continues at a gradual pace to prevent any issues that can sometimes be associated with breaking in a new pair of shoes such as redness, irritation, and blistering.

You may call AuBurn Pharmacy any time within the 5 day trial period, but close to the fifth day, your shoe fitter will call to see how you are doing with your shoes and to ask some follow-up questions.

## Diabetic Shoe Fitting-Patient Information

Prior to shoe fitting appointments:

- Patient will be given forms to fill out and information Medicare requires the pharmacy to provide
- Fill out all pharmacy intake and beneficiary forms, return to the pharmacy
- Copies of primary and secondary insurance card are needed, the pharmacy staff can make copies on location
- Day of Appointment: Wash feet with soap and water; wear socks and shoes that are worn on a regular daily basis

During first fitting appointment:

- Both bare feet will be looked at to assess foot wellness to meet documentation purposes required by Medicare
- Questions will be asked to understand foot health
- Both feet will be measured with socks on, using one or more measuring devices
- Shoes will be picked out with the aide of the shoe fitter, displays and catalogs and an order form will be filled out by fitter for patient to sign
- Heat-moldable are standard inserts unless otherwise specified by the prescriber. If custom inserts are order an impression of both feet will be made

During final fitting appointment:

- Heat-moldable inserts are heated until pliable and molded to patient's feet with the help of the shoe fitter. All three pairs will be molded at the time of the fitting.
- A pair of inserts will be put into shoes for try-on. Patient will walk around to check for heel slip and the fitter will assess for good width and length.
- A paper copy of shoe break-in instructions will be provided.
- A Proof of Delivery and Return Policy Form will be signed by the patient.

After the appointments:

- Break-in new shoes according to the instructions provide by the shoe fitter and the take home instructions
- Patient may call with any question or concerns during the 5 day break-in period.
- Shoe fitter will call around day 5 to see how patient is doing and to ask some follow-up questions



### **Medicare Proof of Delivery and Return Policy for Diabetic Shoes**

The policy of AuBurn Pharmacy, in conjunction with the Shoe Manufacturer, is that any problems with the shoes you received are returnable. The requirements for return include, wearing shoes only inside and not on any hard surfaces and returning shoes in a reasonable amount of time after the order is placed. (30 days) We will review any defects associated with wear and evaluate the return on an individual basis. This form also states that you are aware and agree with this policy when you receive your shoes.

I have had my final fitting for the diabetic shoes and have had the inserts molded for me. I find no problems at the time that I have taken delivery of my shoes and inserts.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_



## Diabetic Shoes Checklist – Medicare Part B

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Initial fitting scheduled for: \_\_\_\_\_

Final fitting scheduled for: \_\_\_\_\_

Follow-up documents due by: \_\_\_\_\_

### ***Initial paperwork required from patient:***

- DME intake form
- Assignment of benefits form
- Warranty information
- Copy of patient's Medicare red, white, and blue card (*front and back*)
- Copy of patient's supplemental insurance card (*front and back*)
- Patient received business card with employee information who will be providing the shoes

### ***Documents required from prescriber(s):***

- Valid order/prescription from APRN/PA-C/MD/DO for diabetic shoes and heat-moldable inserts (*must specify quantities and be dated on or after the date of foot exam records*)
- Certifying statement from MD/DO (*not older than 3 months*)
- Medical records of foot exam indicating shoe need (*not older than 6 months*)
- Medical records of diabetes management (*not older than 6 months and signed/co-signed by MD or DO*)

### ***Documents required for fitting/delivery of diabetic shoes:***

- Checklist for initial fitting of diabetic shoes
- Final fitting for diabetic shoes
- Follow-up for diabetic shoes (*completed at one week*)
- Patient satisfaction survey (*completed at time of follow-up*)
- Follow-up form for new diabetic patients (*completed at one week*)
- Medicare proof of delivery and return policy for diabetic shoes
- Patient received copy of patient information packet (*description of shoe fittings, supplier standards, HIPAA statement, equipment warranty information, complaint protocol, patient rights and responsibilities*)

AuBurn Pharmacy  
Pt Services Chapter 8

FINAL FITTING OF  
DIABETIC SHOES

PATIENT NAME: \_\_\_\_\_ DATE OF FITTING \_\_\_\_\_  IN PERSON VISIT DOCUMENTED

ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_\_

ALL AREAS REVIEWED AT TIME OF FINAL FITTING:

LENGTH OF SHOE CORRECT: YES \_\_\_ NO \_\_\_ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW  
\_\_\_\_\_

WIDTH OF SHOE CORRECT: YES \_\_\_ NO \_\_\_ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW  
\_\_\_\_\_

DEPTH OF SHOE CORRECT: YES \_\_\_ NO \_\_\_ OTHER, PLEASE DOCUMENT PROBLEM AREA BELOW  
\_\_\_\_\_

PATIENT FOOT STATUS AT TIME OF FINAL FITTING/DELIVERY OF SHOES

	YES	NO	OTHER, PLEASE EXPLAIN
PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REDNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOBILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SORENESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIABETIC SHOE BREAK IN FORM PROVIDED AT TIME OF FINAL FITTING YES \_\_\_ NO \_\_\_  
DO YOU CURRENTLY HAVE ANY OTHER CONCERNS WITH YOUR DIABETIC SHOES? YES \_\_\_ NO \_\_\_

DID CUSTOMER WALK AROUND IN THE SHOE AND DETERMINE IF ANY AREAS OF CONCERN ARE PRESENT?  
YES \_\_\_ NO \_\_\_ IF AREA OF CONCERN PLEASE DOCUMENT: \_\_\_\_\_

DID PROVIDER HEAT MOLD INSERTS TO THE CUSTOMER? YES \_\_\_ NO \_\_\_ IF ANY PROBLEMS PLEASE  
EXPLAIN \_\_\_\_\_

IS THERE ANY SLIPPING IN THE HEEL? YES \_\_\_ NO \_\_\_

IS THE CUSTOMER WEARING THE HOSE, SOCKS, ETC: THAT THEY WILL BE WEARING WITH THE DIABETIC SHOES? YES \_\_\_ NO \_\_\_

DO THE SHOES FIT THE NEED OF THE CUSTOMER AT THIS TIME? YES \_\_\_ NO \_\_\_

DO ANY MODIFICATIONS NEED TO BE MADE TO THE FIT OF THE SHOE? YES \_\_\_ NO \_\_\_ IF ANY PLEASE  
EXPLAIN \_\_\_\_\_

ADDITIONAL NOTES:

FOLLOW-UP VISIT RECOMMENDED  \_\_\_\_\_ FOLLOW-UP BY PHONE & AS NEEDED

Employee Signature \_\_\_\_\_ Date of final fitting \_\_\_\_\_



**Order for Diabetic Shoes and Inserts**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

1. Type of shoes prescribed (must check):

Extra Depth (A5500) - 1 pair, unless otherwise noted

2. Type of inserts prescribed (must check one):

Heat Moldable (A5512) - 3 pairs, unless otherwise noted

Custom Fabricated (A5513) - 3 pairs, unless otherwise noted

3. Diagnosis Code(s): \_\_\_\_\_

ICD Notes and/or Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Must be a M.D., D.O., D.P.M., P.A., N.P. OR Clinical Nurse Specialist)  
(Original Signature and Date Required, NO signature or date stamps)



## Statement of Certifying Physician for Therapeutic Shoes

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Medicare#: \_\_\_\_\_

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
  - a. History of partial or complete amputation of the foot
  - b. History of previous foot ulceration
  - c. History of pre-ulcerative callus
  - d. Peripheral neuropathy with evidence of callus formation
  - e. Foot deformity
  - f. Poor circulation
3. I am treating this patient under a comprehensive plan of care for their diabetes.
4. This patient needs special shoes (extra-depth or custom molded shoes) because of their diabetes.

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Must be a M.D. or D.O.) (Original Signature and Date Required, NO signature or date stamps)



Name: \_\_\_\_\_ Date of initial fitting: \_\_\_\_\_

## Check List for Fitting Diabetic Shoes (First Fitting)

1. Fill out the appropriate paper work.
  - A. Forms in prepared file. Copy all Insurance cards (front and back)
  - B. Prescription from Physician certifying that they are diabetic and will Benefit from diabetic shoes.
2. Make sure that the Patient qualifies for billing shoes to Medicare by checking one of the following criteria:
  - A. The patient has diabetes mellitus ( ICD-9 Diagnosis codes 250.00-250.91)
  - B. The patient has one or more of the following conditions:
    1. Poor circulation in either foot.
    2. Foot deformity of either foot.
      - a. Bunions
      - b. Bunionettes
      - c. Hammer Toes
      - d. Other \_\_\_\_\_
    3. History of pre ulcerated calluses of either foot.
    4. History of foot ulceration
    5. Peripheral neuropathy with evidence of callus formation
    6. History of partial or complete amputation of the foot.
3. Do you check your blood sugar? \_\_\_\_\_  
How often and what was it the last check? \_\_\_\_\_
4. List all complications that the patient has concerning the feet.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Note the extent of wear on the shoes they are wearing today.  
\_\_\_\_\_  
Are they too tight? \_\_\_\_\_ If so, where? \_\_\_\_\_
6. Note callus locations on foot.  
\_\_\_\_\_  
\_\_\_\_\_

7. Note longest toe. \_\_\_\_\_
8. Are the feet cold or hot? (circle one)
9. Are the feet flexible? \_\_\_\_\_

10. Is there evidence of edema? \_\_\_\_\_
- A. Has patient seen a physician for this problem? If so, who?  
\_\_\_\_\_
- B. Medications or actions taken?  
\_\_\_\_\_  
\_\_\_\_\_

11. Check arch of foot (non-weight bearing) Note the height \_\_\_\_\_

12. Standing position arch: \_\_\_\_\_

13. Measure foot in standing position

**Brannock Device Measurements**

- A. Right heel to toe \_\_\_\_\_
- B. Right foot heel to ball \_\_\_\_\_
- C. Right width \_\_\_\_\_
- D. Left Heel to toe \_\_\_\_\_
- E. Left foot heel to ball \_\_\_\_\_
- F. Left width \_\_\_\_\_

**Ritz Stick Measurements**

- A. Right heel to toe length \_\_\_\_\_
- B. Right width \_\_\_\_\_
- C. Left heel to toe length \_\_\_\_\_
- D. Left width \_\_\_\_\_

Shoe Style Selected: \_\_\_\_\_

Inserts Selected: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICARE 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. 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. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
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.

## HIPAA NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

AuBurn Pharmacy works with you to provide quality prescriptions. This Notice of Privacy Practices ("notice") describes:

- How we may use and disclose your medical information
- Your rights to access and amend your medical information

We are required by law to:

- Maintain the privacy of your medical information
- Provide you with notice of our legal duties and privacy practices with respect to your medical information
- Abide by the terms of this notice

### Permitted Uses and Disclosures of your Medical Information

As permitted by your health plan or prescription benefit plan, we may use and disclose your medical information for the following purposes only:

#### Treatment

We may use and disclose your medical information to healthcare professionals to provide, coordinate and manage the delivery of medical items or services. For example, our pharmacist may disclose medical information about you to your physician in order to coordinate the prescribing and delivery of your medications. We will fill and send to you orders that you send to AuBurn Pharmacy.

#### Payment

We may use and disclose medical information about you to manage your account and process your claims for medications you have received. For example, we may provide you with claim forms containing your information for you to submit to your health plan or employer for payment.

#### Healthcare Operations

We may use and disclose your medical information to carry on our own business planning and healthcare operations. We need to do this so we can provide you with pharmacy benefits and ensure you receive the highest-quality services. For example, we may use and disclose medical information about you to:

- Assess the use or effectiveness of certain medications
- Develop and monitor medical protocols
- Give you helpful medication reminders and health-management services.

At your request, we may send you information about health conditions, medications or promotions. At your request or the request of your health plan, we may send you information or contact you about programs designed to improve your health.

#### Care Coordination and Treatment Reminders

We may use or disclose your medical information to contact you about treatment options or alternatives that may be of interest to you. For example, we may call you to remind you of expired prescriptions, the availability of alternative medications or to inform you of other medications that may benefit your health.

#### Individuals Involved in Your Care or Payment for Your Care

We may disclose medical information about you to someone who assists in or pays for your care. Unless you write to us and specifically tell us not to, we may disclose your medical information to someone who has your permission to act on your behalf. We will require this person to provide adequate proof that he or she has your permission.

#### Business Associates

We may arrange to provide some services through contracts with business associates. On occasion, we may disclose your medical information to business associates acting on our behalf. If any medical information is disclosed, we will protect your information from further use and disclosure using confidentiality agreements.

#### Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. Before we use or disclose medical information about you, we will either remove information that personally identifies you or gain approval through a special approval process designed to protect the privacy of your medical information. In some circumstances, we may use your medical information to generate

aggregate data (summarized data that does not identify you) to study outcomes, costs and provider profiles and to suggest benefit designs for your employer or health plan. These studies generate aggregate data that we may sell or disclose to other companies or organizations. Aggregate data does not personally identify you.

#### Abuse, Neglect or Domestic Violence

We may disclose your medical information to a social service, protective agency or other government authority if we believe you are a victim of abuse, neglect or domestic violence. We will inform you of our disclosure unless informing you will place you at risk of serious harm.

#### Public Health

We may disclose your medical information to a public health department, including the U.S. Food and Drug Administration, when required by law for the reporting or tracking of illnesses, injuries or dangerous preparations.

#### Health Oversight

We may disclose medical information to a health oversight agency performing activities authorized by law, such as investigations and audits. These agencies include governmental agencies (state and federal) that oversee the healthcare system, government benefit programs and organizations subject to government regulation and civil rights laws.

#### To Avert Serious Threat to Health or Safety

We may disclose your medical information to prevent or lessen an imminent threat to the health or safety of another person or the public. Such disclosure will only be made to someone in a position to prevent or lessen the threat.

#### Judicial Proceedings

We may disclose your medical information in the course of any judicial proceeding in response to a court order, subpoena or other lawful process, but only after we have been assured that efforts have been made to notify you of the request.

#### Law Enforcement

We may disclose your medical information, as required by law, in response to a subpoena, warrant, summons or, in some circumstances, to report crime.

#### Coroners and Medical Examiners

We may disclose your medical information to a coroner or a medical examiner for the purpose of determining cause of death or other duties authorized by law.

#### Organ, Eye and Tissue Donation

We may disclose your medical information to organizations involved in organ transplantation to facilitate donation and transplantation.

#### Workers Compensation

We may disclose your medical information in order to comply with workers compensation laws and other similar programs.

#### Specialized Government Functions, Military and Veterans

We may disclose your medical information to authorized federal officials to perform intelligence, counter-intelligence, medical suitability determinations, Presidential protection activities and other national security activities authorized by law. If you are a member of the U.S. armed forces or of a foreign military force, we may disclose your medical information as required by military command authorities or law. If you are an inmate in a correctional institution or under the custody of a law enforcement official, we may disclose your medical information to those parties if disclosure is necessary for 1) the provision of your healthcare; 2) maintaining the health or safety of yourself or other inmates; or 3) ensuring the safety and security of the correctional institution or its agents.

#### As Otherwise Required By Law

We will disclose medical information about you when required to do so by law. If federal, state or local law within your jurisdiction offers you additional protections against improper use or disclosure of medical information, we will follow such laws to the extent they apply.

#### Other Uses and Disclosures

Other uses and disclosures of your medical information not listed in this notice will be made only with your written authorization. You may revoke this authorization at any time unless we have taken action in reliance upon it.

## Your Rights With Respect to Your Medical Information

You have the following rights regarding medical information we maintain about you:

### Right to Inspect and Copy

Subject to some restrictions, you may inspect and copy medical information that may be used to make decisions about you. To do so, submit a written request to AuBurn Pharmacy at the address listed below.

### Right to Amend

If you believe medical information about you is incorrect or incomplete, you may ask us to amend the information. Such request must be made in writing and submitted to AuBurn Pharmacy at the address listed below. In addition, you must provide a reason supporting your request to amend.

### Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures of your medical information. This accounting identifies the disclosures we have made of your medical information other than for treatment, payment or healthcare operations. You must submit your request in writing to AuBurn Pharmacy at the address listed below. The provision of an accounting of disclosures is subject to certain restrictions.

### Right to be Notified

You have the right to be notified following a breach of unsecured PHI if your PHI is affected. This notification will be made by mail unless we do not have a correct mailing address for you, then we may use our web site, media stories or ads to inform you.

### Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use and disclose about you for treatment, payment or healthcare operations. You also may request that your medical information not be disclosed to family members or friends who may be involved in your care or paying for your care. Your request must 1) be in writing; 2) state the restrictions you are requesting; and 3) state to whom the restriction applies. We are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

### Right to Request Disclosures to your Insurance Plan.

You have the right to request that we do not disclose information to your insurance plan about services provided however you must pay for the services in full. If you do not pay for the services within 30 days of first statement date, the restriction is void and we may bill your insurance.

### Confidential Communications

You may ask that we communicate with you in a particular way and in a particular place to protect the confidentiality of your medical information. Your request must be submitted in writing to AuBurn Pharmacy at the address listed below and you must state an alternate method or location you would like us to use to communicate your medical information to you.

### Right to a Paper Copy of This Notice

You have the right to request a paper copy of this notice at any time. For information about how to obtain a copy of this notice and answers to frequently asked questions, please call **(785) 448-3600**. Even if we have agreed to provide this notice electronically, you are still entitled to a paper copy.

### Right to File a Complaint

If you believe we have violated your privacy rights you may file a written complaint to AuBurn Pharmacy at the address listed below. You may also file a complaint with the [Secretary of the Department of Health and Human Services](#). You will not be penalized for filing a complaint. Written complaints and written requests for a copy of your medical information, amendment to your medical information, an accounting of disclosures, restrictions on your medical information or for confidential communications may be mailed to:

AuBurn Pharmacy  
259 W. Park Rd  
Garnett, KS 66032

Please include your name, address. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future.



## Equipment warranty information

Every product sold or rented by our company carries a 1-year manufacturer’s warranty. AuBurn Pharmacy will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. AuBurn Pharmacy will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner’s manual with warranty information will be provided to beneficiaries for all durable medical equipment if manual is available.

### Store Locations

AuBurn Pharmacy	429 N Maple, Garnett, Ks 66032	785-448-6122	Hours: M-F 8:30 – 7:00, Sat 8:30 – 2:00	PTAN# 0524000001
AuBurn Pharmacy	6 S Metcalf Rd, Louisburg, Ks 66053	913-837-5555	Hours: M-F 9:00 – 7:00, Sat 9:00 – 4:00	PTAN# 0524000005
AuBurn Pharmacy	311 N Hospital Dr., Paola, Ks 66071	913-294-3516	Hours: M-F 8:30 – 8:00, Sat 8:30 – 5:00, Sun 11:00-4:00	PTAN# 0524000026
AuBurn Pharmacy	1021 Poplar, Suite A, Wellsville, Ks 66092	785-883-2462	Hours: M-F 8:30 – 6:30, Sat 8:30 – 1:00	PTAN# 0524000006
AuBurn Pharmacy	400 Ames St, Baldwin City, Ks 66006	785-594-0340	Hours: M-F 8:30 – 7:00, Sat 8:30 – 2:00	PTAN# 0524000025
AuBurn Pharmacy	625 Main St, Mound City, Ks 6605	913-795-4435	Hours: M- F 8:30 – 6:00, Sat 8:30 – 2:00	PTAN# 0524000013
AuBurn Pharmacy	13351 Mission Rd, Leawood, Ks 66209	913-469-9315	Hours: M-F 9:00 – 7:00, Sat 9:00- 4:00	PTAN# 0524000020
AuBurn LTC	401 W. Frontier Ln, Suite 300, Olathe, KS 66061	913-294-9125	Hours: M-F 9:00 – 7:00, Sat 1:00- 5:00	PTAN# 0524000007
AuBurn Pharmacy	16611 E 23rd St Independence, MO 64055	816-833-8629	Hours: M- F 9:00 –7:00, Sat 9:00 – 4:00	PTAN# 0524000019
AuBurn Pharmacy	9107 NW 45 HWY, Parkville, Mo 64152	816-587-2211	Hours: M- F 9:00 –7:00, Sat 9:00 – 4:00	PTAN# 0524000021
AuBurn Pharmacy	890 Lakin St Osage City, Ks 66523	785-528-4415	Hours: M-F 8:00 – 6:00, Sat 8:00 – 2:00	PTAN# 4571000001
AuBurn Pharmacy	310 E. 15th Eudora, Kansas 66025	785-690-7575	Hours: M-F 8:30 – 7:00, Sat 8:30—4:00	PTAN# 0524000008
AuBurn Pharmacy	1518 N Buckeye Ave, Abilene, KS 67410	785-263-3770	Hours: M-F 8:00–7:00, Sat 9:00–4:00, Sun 11:00-4:00	PTAN# 6857520002
AuBurn Pharmacy	211 Main St, Carbondale, KS 66414	785-836-7202	Hours: M-F 8:30-5:30 , Sat 9:00–1:00	PTAN# 0524000009
AuBurn Pharmacy	216 N. Harrison, Lindsborg, KS 67456	785-227-3374	Hours: M– F 9:00– 6:00, Sat 9:00– 1, Sun 5:00– 7:00	PTAN#0524000014
AuBurn Pharmacy	1526 Lincoln, Concordia, KS 66901	785-243-1212	Hours: M-F 8:30-6:00, Sat 8:30-2:00	PTAN# 0524000010
AuBurn Pharmacy	209 West 2nd Street, Minneapolis KS 67467	785-392-2213	Hours: M-F 9:00-6:00, Sat 9:00-1:00	PTAN# 0524000012
AuBurn Pharmacy	20375 W. 151st suite 100A, Olathe, KS 66061	913-393-4440	Hours: M-F 8:30-6:00, Sat 9:00-2:00	PTAN# 0524000011
AuBurn Pharmacy	113 E US HWY 54, Camdenton, MO 65020	573-346-3396	Hours: M-F 9:00-6:00, Sat 9:00-1:00	PTAN# 0524000016
AuBurn Pharmacy	1200 E. 10th. Suite B, Holden, MO 64040	816-732-5514	Hours: M-F 9:00-6:00, Sat 9:00-1:00	PTAN# 0524000017
AuBurn Pharmacy	301 North 14th, Rich Hill, MO 64779	417 -395-4700	Hours: M-F 9:00-6:00	PTAN# 0524000023
AuBurn Pharmacy	105 S Oak, Nevada, MO 64772	417-667-7802	Hours: M-F 9:00-6:00, Sat 9:00-6:00	PTAN# 0524000027
AuBurn LTC	125 S Washington STE 200, Nevada, MO 64772	417-667-2500	Hours: M-F 9:00-6:00, Sat 9:00-3:00	PTAN# 0524000022
AuBurn Pharmacy	54B SE 1st Lane,Lamar, MO 64759	417-682-5838	Hours: M-F 9:00-6:00, Sat 9:00-1:00	PTAN# 0524000018
AuBurn Pharmacy	6 W Broadway, Lebo, KS 66856	620-256-6122	Hours: M-F 8:00-6:00, Sat 8:00-1:00	PTAN# 0524000015
AuBurn Pharmacy	5318 W Central Ave, Wichita, KS 67212	316-252-8600	Hours: M-F 8:00-5:00, Sat 8:00-12:00	PTAN# 0524000024
AuBurn Pharmacy	810 W 35th St Higginsville, MO 64037	660-584-2700	Hours: M-F 9:00-6:00, Sat 9:00-1:00	PTAN# 0524000028
AuBurn Pharmacy	1109 S 169 HWY, Smithville, MO 64089	816-532-0977	Hours: M-F 9:00-7:00, Sat 9:00-1:00	PTAN#0524000029
AuBurn Pharmacy	716 N 4th St Burlington, KS 66839	620-364-3388	Hours: M-F 9:00-6:00, Sat 9:00-2:00	PTAN#0524000030



## **PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES**

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to the Director of Customer Services or Pharmacy Manager. These complaints will be documented on the Medicare Beneficiary Complaint Summary Log, and completed forms will include the patient's name, address, telephone number, health insurance claim number, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or telephone by the manager/representative within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint protocol at the time of set-up of service.

If you have any unresolved issues, you may file a complaint with our Auburn Corporate Office or our Accrediting Organization.

Auburn Corporate @ 1-785-448-3600

The Compliance Team @ 1-888-291-5353



## AuBurn Pharmacy Patient Rights & Responsibilities

### Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

### Patient Responsibilities:

1. The patient should promptly notify AuBurn Pharmacy of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify AuBurn Pharmacy in such instances.
3. The patient should promptly notify AuBurn Pharmacy of any changes to their address or telephone.
4. The patient should promptly notify AuBurn Pharmacy of any changes concerning their Physician.
5. The patient should notify AuBurn Pharmacy of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

# AuBurn Pharmacy

## DME Intake Form and Delivery Instruction Ticket

<b>Patient Information</b>	
Name: _____	DOB: _____ Gender: ___M___F
Address: _____	City/State/Zip: _____
Phone: _____	SSN# _____
<b>Primary Health Insurance Coverage</b>	<b>Supplemental/ Secondary Insurance Coverage</b>
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: _____
<b>Home Environment/Safety Assessment</b>	<b>Not Applicable - Not Delivered to Home</b>
Discuss all appropriate Factors and check if in order	<b>Appropriate for Home</b>
<input type="checkbox"/> 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	<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)
<b>Physician Information</b>	<b>Equipment Information</b>
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): _____
<b>Supplier information for File Check All</b>	<b>Patient Information: (Check if Pt received all)</b>
<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 <input type="checkbox"/> (Walkers/Diabetic Shoes) <input type="checkbox"/> IVR Called for Same or Similar (Walkers/Canes/ <b>Glucometer/Nebulizer/Wheelchairs</b> ) <input type="checkbox"/> DME Inspection Repair form completed (Walker/ <b>Canes/Glucometer/Nebulizer/Wheelchairs</b> ) <input type="checkbox"/> Capped Rental form signed (Walkers/Canes/ <b>Glucometer/Nebulizer/Wheelchairs</b> ) <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 \_\_\_\_\_

# 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 \_\_\_\_\_



**Medicare Capped Rental Service and  
Inexpensive or Routinely Purchased Item  
Notification for Services on of after January 1, 2006**

I received instructions and understand that Medicare defines the \_\_\_\_\_ that I received as being either capped rental service or an inexpensive or routinely purchased item.

\_\_\_ FOR CAPPED RENTAL SERVICES:

- Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which Ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include:  
Hospital beds, wheelchairs, alternating pressure pads, air fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

\_\_\_ FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

- Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include:  
Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors,(lymphedema pumps), bedside rails, and traction equipment.
- I select the :

Purchase Option \_\_\_\_\_

Rental Option \_\_\_\_\_

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date