AUBURN PHARMACY

Patient Packet- Testing Supplies, Nebulizers, Part B Medications, all other DME Equipment excluding Shoes

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

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.

National Supplier Clearinghouse
P.O. Box 100142 • Columbia, South Carolina • 29202-3142 • (866) 238-9652
A CMS Contracted Intermediary and Carrier

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.

AUBURN PHARMACY®

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 – 1:00	PTAN# 1273520001
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 9:00 – 7:00, Sat 9:00—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 9:00-7:00, Sat 9:00-2:00	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 Highway 54, Camdenton, MO 65020	573-346-3396	Hours: M-F 9:00-6:00, Sat 9:00-5:00	PTAN# 0524000016
AuBurn Pharmacy	1200 E. 10th. Suite B., Holden, MO 64040	816-732-5514	Hours: M-F 9:00-6:00, Sat 9:00-5:00	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, Nevada, MO 64772	417-667-2500	Hours: M-F 9:00-6:00	PTAN# 0524000022
AuBurn Pharmacy	54 S. E. 1st Lane,Lamar, MO 64759	417-682-5838	Hours: M-F 9:00-6:00, Sat 9:00-5:00	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, 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 9:00-12:00	PTAN# 0524000028
AuBurn Pharmacy	1109 S 169th, 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.
AuBurn Pharmacy	1020 Elmhurst Blvd, Concordia, KS, 66901	785-243-4414	Hours: M-F 8:00-6:00, Sat 8:00-12:00	
AuBurn Pharmacy	134 S Main St, Ottawa, KS, 66067	785 242-2055	Hours: M-F 8:00-6:00, Sat 8:00-12:00	

Signature: _____ Date: _____

AUBURN PHARMACY

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

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	**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
- Safe operating equip
- Safe Envrionemnt
- Bathroom Assessed
- Area Rugs
- Fire safety assessed
- Cords & Adapters
- Pt/CG understands safety issues
- Safe electrical outlet
- 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

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

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

Revised: 01/05/2010 sjw

DME Inspection/Repair

Device:_____ **Serial#:**_____

Model#:_____ **Mfr:**_____

Date: _____ **Inspector:**_____

☐ **Inspection** ☐ **Preventive Maintenance** ☐ **Repair**

If device is electrical use orthopedic inspection/repair form

	YES	NO	Actions taken
Device in good working order			
Plates, Knobs, Screws ,Bolts present			
Controls/Switches			
Wheels, Castors, Brakes appropriate			
Cords/Straps			
Accessories/attachments in order			
Device clean & disinfected			
If new/delivered in box			
If a purchase include operating manual			
Device is patient Ready			

List Problem/If in for Repair

Services Performed

☐ **Sent back to inventory** ☐ **Sent to Manufacturer** ☐ **Incident**

General DME Instruction Delivery

Name:	Date of Visit
Address:	☐ Initial Delivery
Phone:	
Alternate Contact:	Phone:

PRODUCT KNOWLEDGE/SAFETY ASSESSMENT

Discuss all appropriate factors and √ if in order ☐ **PRODUCT KNOWLEDGE** ☐ **SAFETY** ☐ **PRODUCT DEMONSTRATION (if applicable)** ☐ **OTHER:** _____ _____ _____ _____	**APPROPRIATE FOR PATIENT** ☐ Yes ☐ No ☐ Return Demo. by patient (if applicable) ☐ Patient demonstrated understanding of equipment Information ☐ Patient/Caregiver expressed personal/physical limit (describe below) _____ _____ _____

EQUIPMENT

Device/s:	Serial #
Make: Manuf:	Model:

LIST TYPE OF PRODUCT(S)

ADDITIONAL INSTRUCTIONS

ADDITIONAL NOTES

FOLLOW UP/DISCHARGE

I have read, received and/or been instructed in detail on the items checked above.

(If Patient unable to sign; authorized person complete)

PATIENT SIGNATURE:	**Print name/relationship:**
EMPLOYEE SIGNATURE:	**Authorized Signature:**

DME Instruction Delivery- Walkers/Rollators

Name:	Date of Visit
Address:	☐ Initial Delivery
Phone:	
Alternate Contact:	Phone:
HOME ENVIRONMENT/SAFETY ASSESSMENT	
Discuss all appropriate factors and √ if in order ☐ **SAFETY** Uncluttered pathways Area Rugs Other:_____	**APPROPRIATE FOR HOME** ☐Yes ☐No ☐Alert & Understands ☐ Return Demonstration by patient ☐Confused/ caregiver instructed Personal/Physical limit _____ _____
EQUIPMENT	
Device/s:	Serial #
Make: Manuf:	Model:
√ TYPE OF PRODUCT	
☐ Walker_____	
☐ Walker with wheels_____	
☐ Rollator (walker/seat)_____	
☐ Rollator- basket attach_____	
ADDITIONAL INSTRUCTIONS	
ADDITIONAL NOTES	
FOLLOW UP/DISCHARGE	
I have read, received and/or been instructed in detail on the items checked above.	
(If Patient unable to sign; authorized person complete)	
PATIENT SIGNATURE:	**Print name/relationship:**
EMPLOYEE SIGNATURE:	**Authorized Signature:**

GENERAL DME FOLLOW-UP PLAN OF CARE

PATIENT NAME: _____ DATE: _____ ☐ VISIT ☐ PHONE
ADDRESS: _____ DOB: __/__/____ SOC-SEC-#_____
TELEPHONE: _____ ALT. CONTACT: _____ ALT. TEL: _____
DIAGNOSIS: _____ PHYSICIAN: _____ PH#:_____

~~~~~~ALL ITEMS REVIEWED AND UNCHANGED √ BOX ONLY IF CHANGED & NOTE CHANGE~~~~~~

☐ SAFETY AND ENVIRONMENT _____
☐ OTHER HOME CARE SERVICES _____
☐ EQUIPMENT USE, OPERATION _____
☐ CLEANING & MAINTENANCE _____
☐ SERVICES & COMPLAINTS _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~PATIENT STATUS- DESCRIBE PRODUCT OPINION~~~~~~~~~~~~~~~~~~~~~~~~~~~~

_____
_____
_____
_____
_____

SOURCE OF INFORMATION: _____

~~~~~~EQUIPMENT SETTINGS~~~~~~

DEVICE: _____ **SERIAL/BATCH/LOT#**_____

USE	**INCREASE**	**DECREASE**	**SAME**
FREQUENCY: _____	☐	☐	☐
DURATION: _____	☐	☐	☐
SETTINGS: _____	☐	☐	☐
_____			

LENGTH OF TIME USING EQUIPMENT: _____

~~~~~~ADDITIONAL NOTES~~~~~~

NEED	**GOAL**	**RESULTS**

~~~~~~FOLLOW-UP/DISCHARGE~~~~~~

FOLLOW-UP VISIT RECOMMENDED ☐ _____ **FOLLOW-UP BY PHONE & AS NEEDED** ☐ _____
NEXT DR. VISIT: _____ **EQUIP TO BE P/U:** _____

I HAVE READ, RECEIVED AND BEEN INSTRUCTED IN DETAIL ON THE ITEMS CHECKED ABOVE.

Patient/Auth Rep Signature: _____

Name of authorized person (print): _____

Relationship_____**Why Pt Cannot Sign:** _____

Employee Signature: _____

WALKER/ROLLATOR- FOLLOW-UP PLAN OF CARE

PATIENT NAME :______________________________ DATE: __________ ☐ VISIT ☐ PHONE
ADDRESS: ______________________________ DOB: / / ______ SOC-SEC-#__________
TELEPHONE: ______________ ALT. CONTACT: ______________ ALT. TEL: __________
DIAGNOSIS: ______________________ PHYSICIAN:________________ PH#:__________

~~~~~~ALL ITEMS REVIEWED AND UNCHANGED √ BOX ONLY IF CHANGED & NOTE CHANGE~~~~~~

☐ SAFETY AND ENVIRONMENT ______________________________
☐ OTHER HOME CARE SERVICES ______________________________
☐ EQUIPMENT USE, OPERATION ______________________________
☐ CLEANING & MAINTENANCE ______________________________
☐ SERVICES & COMPLAINTS ______________________________

~~~~~~PATIENT STATUS- DESCRIBE PRODUCT OPINION~~~~~~

	IMPROVED	SAME	WORSE
PAIN,	☐	☐	☐
STIFFNESS,	☐	☐	☐
SWELLING	☐	☐	☐
MOBILITY	☐	☐	☐

SOURCE OF INFORMATION: ______________________________

~~~~~~EQUIPMENT SETTINGS~~~~~~

DEVICE: ______________________ SERIAL/BATCH/LOT#______________________

USE		INCREASE	DECREASE	SAME
FREQUENCY:	______________	☐	☐	☐
DURATION:	______________	☐	☐	☐
SETTINGS:	______________	☐	☐	☐
	______________			

LENGTH OF TIME USING EQUIPMENT: ______________________

~~~~~~ADDITIONAL NOTES~~~~~~

NEED GOAL RESULTS

____

____

~~~~~~FOLLOW-UP/DISCHARGE~~~~~~

FOLLOW-UP VISIT RECOMMENDED ☐ ____________ FOLLOW-UP BY PHONE & AS NEEDED ☐ ____________
NEXT DR. VISIT: ______________________ EQUIP TO BE P/U: ______________________

I HAVE READ, RECEIVED AND BEEN INSTRUCTED IN DETAIL ON THE ITEMS CHECKED ABOVE.

Patient/Auth Rep Signature: ______________________________

Name of authorized person (print): ______________________________

Relationship______________ Why Pt Cannot Sign: ______________________________

Employee Signature: ______________________________
~~~~~~

AUBURN PHARMACY

Store #_____

AuBurn Pharmacy Satisfaction Measure

Date of Service_____

Survey Method ○ In Store ○ By Phone

Patient_____Phone #_____

Equipment Provided_____ ○New ○Existing

Model_____ Serial #_____

Survey Conducted by_____

Survey Conducted on _____

Delivery and Instruction Tech Names_____

Access, Delivery, and Service

Equipment/supplies were delivered in a timely manner.	Yes	No	N/A
Equipment/supplies were ready for patient use upon delivery.	Yes	No	N/A
Received and understood instructions on proper application and use of equipment/supplies.	Yes	No	N/A
Feel confident to operate/use equipment/supplies.	Yes	No	N/A
Received info on my Rights & Responsibilities, complaint process, billing, contact numbers.	Yes	No	N/A
Satisfied with equipment or supplies.	Yes	No	N/A
Satisfied with the service. Would recommend to others.	Yes	No	N/A

Comments: