New Patient Packet

DME/HME

PATIENT INFORMATION PACKET

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***YOU MAY USE OUR **AFTER HOURS** CALL LINE TO PHONE IN YOUR REFILL PRESCRIPTIONS.
CALL (*PHONE NUMBER*) AND FOLLOW THE PROMPTS.

Welcome to Your Store Name Here!

At **Your Store Name Here** we are committed to providing for your prescription needs by supplying your medications in a timely manner and at an affordable price. We have a $4 generic medication list with over 300 medications listed. **Your Store Name Here** also accepts most prescription insurance plans and we can file your secondary insurance for you as well.

DURABLE MEDICAL EQUIPMENT

At Your Store Name Here we offer a variety of durable medical supplies including crutches, canes, diabetic foot wear and rolling walkers complete with seats and baskets attached. Our staff will instruct you on how to use the equipment and answer any questions you may have. We will also file your Medicaid and Medicare insurance for these items as well.

DRUG INTERACTIONS

Whether you are purchasing over-the-counter medications or you have a prescription from your doctor, you need to be made aware of any negative drug interactions. At Your Store Name Here our pharmacists and computer systems work together to prevent these types of occurrences. Remember to let your pharmacist know if you are taking any over the counter medications in addition to your new prescriptions. We are concerned about your health and our goal is to prevent any adverse drug reactions.

YOUR STORE NAME HERE COUNSELING

Our pharmacists are available when you have any questions concerning your medications or need assistance with purchasing over-the-counter meds and supplies. Our pharmacists are knowledgeable professionals and will gladly take the time to show you how to use the medications or supplies prescribed by your doctor. Just ask to speak to a pharmacist when you pick up your prescriptions and we will assist you right on the spot!

INSURANCE COUNSELING

Perhaps you or your spouse qualifies for Medicare Part D prescription coverage but you don't know which plan will be best for you. **Your Store Name Here** makes these types of decisions easy for you. We have an insurance specialist that will assist you with choosing the right plan. Call today to make an appointment for Medicare Part D counseling. It's just that simple.

YOUR STORE NAME HERE STORE

Not only do we take care of your medication needs, we have a mini-dollar store located inside the Your Store Name Here as well. We stock a variety of household items, infant and novelty gifts, pet items and greeting cards. So come on in and browse our aisles while you wait for your prescriptions.

BILL OF PATIENT RIGHTS AND RESPONSIBILITIES

Your Store Name Here supports the Patient's Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. **Your Store Name Here** has an obligation to protect and promote the rights of their patients, including the following rights:

RIGHTS

As the patient/ caregiver, you have the RIGHT to:

- Be treated with dignity and respect.
- Confidentiality of patient records and information pertaining to a patient's care.
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment.
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care.
- Be notified in advance of any change in your plan of care and treatment.
- Be provided equipment and service in a timely manner.
- Receive an itemized explanation of charges.
- Be informed of company ownership.
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property.
- Be informed of potential reimbursement for services under Medicare, Medicaid or other third party insurers based on the patient's condition and insurance eligibility (to the best of the company's knowledge).
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third party insurers. (to the best of the company's knowledge).
- Be notified within 30 working days of any changes in charges for which you may be liable.
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed, if Your Store Name Here is unable to provide services then we will provide alternative resources.
- Purchase inexpensive or routinely purchased durable medical equipment.
- Have the manufacturer's warranty for equipment purchased from "Your Store Name Here" honored.
- Receive essential information in a language or method of communication that you understand.
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected.
- Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- The patient has the right to access, request amendment to, and receive an accounting of disclosures regarding his or her health information as permitted under applicable law.

CLIENT RESPONSIBILITIES

As the patient/caregiver, you are RESPONSIBLE for:

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participation in the plan of care/treatment.
- Notify the company of any change in condition, physician orders, or physician.
- Notifying the company of any incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

Supplier Rights

As your pharmacy of choice we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our Your Store Name Here to secure medication or durable medical equipment.
- To refuse services to anyone who enters our **Your Store Name Here** and is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

Patient Information

- After Hours Services: The after-hours phone number is (**123) 456-7890**. You may leave a message after normal business hours for prescription and/or durable medical equipment needs.
- Complaint Procedure: You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination or unreasonable interruption of services. The telephone number is (**123) 456-7890**; when you call ask to speak with the Director of Your Store Name Here Services or the Your Store Name Here Manager.
- Your Store Name Here has a formal grievance procedure that ensures your concerns will be reviewed and an investigation started within 48 hours. Every attempt shall be made to resolve all grievances within 14 days. You will be informed in writing of the resolution of the complaint/grievance.
- If you feel the need to further discuss unresolved concerns, dissatisfaction or complaints with other than Your Store Name Here staff, the State Attorney General's Services at **(800) 621-0508**.
- The toll-free number for Medicare to file a complaint/or to speak with customer service is **1-800-MEDICARE**.

EMERGENCY PREPAREDNESS PLAN

Your Store Name Here has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact **Your Store Name Here** regarding any medications you may require when there is a threat of disaster or inclement weather so that you have enough medications to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. **Your Store Name Here** will utilize every resource available to continue to service you. However, there may be circumstances where **Your Store Name Here** cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of you local rescue or medical facility. **Your Store Name Here** will work closely with authorities to ensure your safety.

Home Safety Information

Here are some helpful guidelines to help you keep a careful eye on your home and maintain safe habits. The safe way is always the right way to do things. Shortcuts may hurt. Correct unsafe conditions before they cause an accident. Take responsibility and keep your home safe. Keep emergency phone numbers handy.

Medicines

- If children are in the home, store medications and poisons in childproof containers and out of reach.
- All medicines should be labeled clearly and left in original containers.
- Do not give or take medicines that were prescribed for other people.
- When taking or giving medicines, read the label and measure doses carefully. Know the side effects of the medicines you are taking.
- Throw away outdated medicines by pouring down a sink or flushing down the toilet.

Mobility Items

- When using mobility items to get around such as; canes, walkers, wheelchairs or crutches you should use extra care to prevent slips and falls.
- Use extreme care to avoid using walkers, canes or crutches on slippery or wet surfaces.
- Always put wheelchairs or seated walkers in the lock position when standing up or before sitting down.

Wear shoes when using these items and try to avoid obstacles in your path and soft and uneven surfaces.

Slips and Falls

- Slips and falls are the most common and often the most serious accidents in the home.
- Here are some things you can do to prevent them in your home.
- Arrange furniture to avoid an obstacle.
- Install handrails on all stairs, showers, bathtubs and toilets.
- Keep stairs clear and well lit.
- Place rubber mats or grids in showers and bath tubs.
- Use bath benches or shower chairs if you have muscle weakness, shortness of breath or dizziness.
- Wipe up all spilled water, oil or grease immediately.
- Pick up and keep surprises out from under foot, including electrical cords and throw rugs.
- Keep drawers and cabinets closed.
- Install good lighting to avoid groping in the dark.

Lifting

If it is too big, too heavy or too awkward to move alone -GET HELP. Here are some things you can do to prevent low back pain or injury.

- Stand close to the load with your feet apart for good balance.
- Bend your knees and "straddle' the load.
- Keep your back as straight as possible while you lift and carry the load.
- Avoid twisting your body when carrying a load.
- Plan ahead - prepare your way.

Electrical Accidents

Watch for early warning signs - overheating, a burning smell, sparks. Unplug the appliance and get it checked right away. Here are some things you can do to prevent electrical accidents.

- Keep cords and electrical appliances away from water.
- Do not plug cords under rugs, through doorways or near heaters. Check cords for damage before use.
- Extension cords must have a big enough wire for larger appliances.
- If you have a broken plug, outlet or wire, get it fixed right away.
- Use a ground on 3-wire plugs to prevent shock in case of electrical "fault."
- Do not overload outlets with too many plugs.
- Use three-prong adapters when necessary.

Smell Gas

- Open windows and doors.
- Shut off appliance involved. You may be able to refer to the front of your telephone book for Instructions regarding turning off the gas to your home.
- Don't use matches or turn on electrical switches.
- Don't use telephone - dialing may create electrical sparks.
- Don't light candles.
- Call Gas Company from a neighbor's home.
- If your gas company offers free annual inspections, take advantage of them.

Fire

Pre-plan and practice your fire escape. Look for a plan which includes at least two ways out of your home. If your fire exit is through a window, make sure it opens easily. If you are in an apartment, know where the exits stairs are located. Do not use the elevator in a fire emergency. You may notify the fire department ahead of time

if you have a disability or special needs. Here are some steps to prevent fires:

- Install smoke detectors. They are your best early warning. Test frequently and change the battery every year.
- If there is oxygen in use, place a "No Smoking" sign in plain view of all persons entering the home.
- Throw away old newspapers, magazines and boxes.
- Empty wastebaskets and trashcans regularly.
- Do not allow ashtrays to be emptied into trashcans or toss matches into wastebaskets unless you know they are out. Wet down first or dump into toilet.
- Have your chimney and fireplace checked frequently. Look for and repair cracks and loose mortar.
- Keep paper, wood and rugs away from area where sparks could hit them.
- Be careful when using space heaters.
- Follow instructions when using heating pads to avoid serious burns.
- Check your furnace and pipes regularly.
- Keep a fire extinguisher in your home and know how to use it.

If you have a fire or suspect a fire:

- Take immediate action per plan -Escape is your top priority.
- Get help on the way - with no delay. CALL 911.
- If your fire escape is cut off, close the door and seal the cracks to hold back smoke. Signal help from the window.

****IF YOU ARE DEPENDENT ON UTLITIES *(*gas, phone, electricity) FOR EQUIPMENT SUCH AS OXYGEN CONCENTRATORS OR A C-PAP MACHINE, REGISTER AS A HIGH PRIORITY CUSTOMER WITH YOUR UTILITY COMPANY.* ****

NOTICE OF PRIVACY PRACTICES

— — 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.

USES AND DISCLOSURES: We will use and disclose elements of your protected health information (PHI) in the following ways: **Without your signed authorization:**

- Treatment: including, but not limited to, inpatient, outpatient or psychiatric care
- To Medical Center Medical Staff treating physicians.
- Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment;
- preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney
- Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
- Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions,
- Uses or disclosures for specialized government functions: including, but not limited to, the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- In emergency situations or to avert serious health & safety situations.
- If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities.
- Disclosures of identified information.
- Disclosures relating to worker's compensation claims.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organizations that handle organ and tissue donations.
- To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
- We may include certain limited information about you in the hospital directory while you are a patient at the hospital.
- This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- You may be contacted by the hospital to remind you of any appointments, healthcare treatment alternatives and other health-related benefits and services offered by the hospital.
- You may be contacted by the hospital for the purposes of raising funds to support the hospital's operations.

Other Uses and Disclosures:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Your Rights: You have the following rights concerning your protected health information (PHI)

Restrictions: To request restricted access to all or part of your protected health information (PHI). To do this, contact the HIPAA Privacy and Security Officer. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.

Confidential Communications To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the HIPAA Privacy and Security Officer. We will take reasonable actions to accommodate your request.

Access: To inspect or receive copies of your protected health information (PMI) To do this, contact the HIPAA Privacy and Security Officer. In certain circumstances you may not have the right to access your records if Your Store Name Here reasonably believes (or has reason to believe) that such access would cause harm. Examples include, but are not limited to, certain, psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Amendments / Corrections: To request changes be made to your protected health information (PHI). To do or the record is accurate and complete. If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.

Accounting: To receive an accounting of the disclosures by us of your protected health information (PMI) in the six years (or shorter time) prior to your request. To do this, contact the HIPAA Privacy and Security Officer. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures, you are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30 day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This Notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact Your Store Name Here (000) 000-0000 or Your Store Name Here HIPAA Privacy and Security Officer at (000) 000-0000. The law forbids us from taking retaliatory action against you if you complain.

Our Duties; We are required by law to maintain the privacy of your protected health information (PHI). We must abide by the tetras of this notice or any update of this notice.

Privacy Contact: For more information about our privacy practices,
please contact:

The Security Officer or Owner, Place Name Here at (123) 456-7890

As a patient of **Your Store Name Here** you acknowledge that you understand the following:

COLLECTION OF SOCIAL SECURITY NUMBERS NOTICE

State law provides that State agencies, including **Your Store Name Here** must notify individuals of the circumstances that would require collection of social security numbers. The following are the general scenarios under which **Your Store Name Here** must collect and use social security numbers: Insurance and health benefit eligibility, classification of accounts; customer identification and verification; credit worthiness; customer billing and payments; payroll and human resource functions; benefit processing, tax reporting, and any other lawful purpose necessary to conduct Your Store Name Here business.

Social Security numbers are NOT public records, but may be released to other government or commercial entities as required by law.

LIFETIME AUTHORIZATION ASSIGNMENT OF BENEFITS AND INFORMATION RELEVANT

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize **Your Store Name Here** to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to **Your Store Name Here**. I hereby authorize **Your Store Name Here** to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Your Store Name Here** for prescription medications or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical Information about me to release to the Health Care Financing Administration and it's agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is Indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-pays, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

CONSENT FOR TWO PARTY REVIEW

I understand that there may be occasion that my medical record would need to be provided for review by an outside third party (such as accreditation or other) and I have given you my consent for such review as needed.

SUPPLIER STANDARDS

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 or cell phone 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. Supplier Enrollment Chapter 2 Fall 2016 DME MAC Jurisdiction C Supplier Manual Page 7
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. Supplier Enrollment Chapter 2 Fall 2016 DME MAC Jurisdiction C Supplier Manual Page 8
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions

Protected Health Information

In accordance with **Your Store Name Here's** Notice of Privacy Practices and to protect the confidentiality of my protected health information, I hereby direct that disclosure of my protected health information be restricted. Specifically, no documentation of any information related to my stay or treatment, including but not limited to, any documents or other materials prepared for peer review, risk management, or quality assurance purposes, is to be disclosed under any circumstances, redacted or otherwise, to anyone not affiliated with **Your Store Name Here**, for any purpose other than payment or legitimate health care operations, without my express written consent or the express written consent of my authorized representative.

Patient signature________________________________ Date: ________________________

Witness _______________________________Printed name and title of witness:_________________________________

Effective Date: This notice is effective DATE HERE. I acknowledge receipt of this notice;

Signature: ______________________________________ Date:____________________________

Printed name of patient ____

If you are signing as the patient's representative, print your name:____
Describe your authority: ____

Receipt of Instructions for Equipment Use

Date: ____

Patient Name: ____

Print Print

Item purchased: ____

Please Print

To Whom It May Concern:

I have received verbal and written instructions on how to use the durable medical equipment that I have rented/purchased from **Your Store Name Here.** I have also been informed of the warranty that this equipment provides to the leaser/purchaser. I understand that Medicare defines some items as inexpensive or routinely purchased items. I understand rented items have a 13 month rental cycle and at the end of 13 months Title of Ownership of the rented item is transferred to the leasee. I understand if the leasee of rented items no longer needs the rented item, and the item is still within the 13 month rental time, the leasee is to contact **Your Store Name Here** as soon as possible and return the rented items to our store.

Patient Signature: ____ Date:______________________

Instructor Signature: ____ Date:______________________

BENEFICIARY SIGNATURE PAGE

The contents of the Patient Intake Packet have been discussed with me and I understand my right as a beneficiary. I have received a copy of The Medicare Quality Standards. I have been instructed in the use and operation of the supplies/equipment that I have received.

Patient signature ____ Date _________________

Printed name of patient ____

Witness Signature ____ Date _________________

Printed name and title of witness: ____

If you are signing as the patient's representative, print your name:

____

State your authority:

____

Date: ______________________

Form Instructions
Advance Beneficiary Notice of Noncoverage (ABN)
OMB Approval Number: 0938-0566

OVERVIEW

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. They must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that Medicare inpatient hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs) use other approved notices for this purpose.) Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid; and notifiers must begin using the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past 3 years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting pre-printing of the lab-specific key information and denial reasons used in the current ABN-L.

Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the Act, the revised version of the ABN may also be used to provide voluntary notification of financial liability. Thus, this version of the ABN should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.

Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual, Publication 100-04, Chapter 30, §50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (www.cms.hhs.gov).

Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.hhs.gov/BNI . Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes. In addition to the generic ABN, CMS will also provide alternate versions, including a version illustrating laboratory-specific use of the notice.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

Sections and Blanks

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

B. Body

Blank (D): The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory test
- Test

- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be noncovered under the header of Blank (D).
- In the case of partial denials, notifiers must list in Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

Blank (E) Reason Medicare May Not Pay: In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D).

Blank (F) Estimated Cost: Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

<u>For a service that costs $250</u>:

- Any dollar estimate equal to or greater than $150
- "Between $150-300"
- "No more than $500"

<u>For a service that costs $500</u>:

- Any dollar estimate equal to or greater than $375
- "Between $400-600"

- “No more than $700”

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. Options

Blank (G) Options: Blank (G) contains the following three options:

❑**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.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier’s obligation to bill Medicare.*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

❑**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**.

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

❑**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.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no

circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option".

D. Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable ;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

(A) **Notifier(s):** ____

(*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. ____

Form CMS-R-131 (03/08) Form Approved OMB