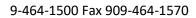
Chino CA 91710





Order Intake						
Order Rece	eived		Order Dispensed			
Date:			Date:	Time:		
Ву:			Rep:			
Patient Inf	ormation:		Subscriber (If diffe	rent from patient/facility)		
Name:			Name Facility:			
Address:			Address:			
City/State:	Zip:		City/State:	Zip:		
Phone:			Phone:			
Insurance I	Insurance Information:					
			Secondary:			
ID#						
Address:			Address:			
City/State:	Zip:		City/State:	Zip:		
Phone:			Phone:			
Clinical Info	ormation:					
DOB:						
Action Tak	en:					
	Representative notified	Insurance Information Obtained	CMN Sent	Medicare Elig Cleared Y N		
	Pre-authorization done	Patient/Facility Contacted	CMN Received	Medi Cal/IEHP/Molena Y N		
		Same or Similar	r Cleared Y N			
Physician Information:						
Name:			Phone:			
Address:			City/State:			
NPI:			Lic#			



Advanced Beneficiary Notice

Members Name:				
NOTE: You need to make a choice about rece After reviewing our records, it appears that y item (s) described below. Most health plan in generally only pay for covered items and serv your insurance may not pay for the item does to pay for these item (s) if you choose to.	our health plan insurance was surances do not pay for all vices that are considered St	will not pay for the total cost of the of your health care costs and candard Medical Benefits. The fact that		
Items	Insurance Allowable	Members Share		
Totals				
The purpose of this form is to help you make these items, knowing that you might have to about your options you should read this entir	pay at least part or all of it	yourself. Before you make a decision		
Why your insurance probably will not	pay for these items.			
Any options for obtaining these items that my insurance might pay the total cost.				
I want to receive these items				
I understand that my insurance may not pay	for the total cost of all the	items. I understand		
That I may have to pay for some or all of the	products stated above. If m	ny insurance does pay for all the		
services you will refund any over payments,				
x x				

Signature of member or person acting on the member's behalf

Date



Medicare Capped Rental and Inexpensive or Routinely

Purchased Items Notification for Services on or after January 2006

I received instructions and understand that Medicare defines the that I received as being either a capped rental or an inexpensive or routinely purchase item.

Beneficiary Signature

inexpensive or routinely purchase item.				
FOR CAPPED	RENTAL ITEMS:			
equipmentAfter ownerresponsibitExamples on Ho	t is transferred to the Medicare be ership of the equipment is transfe ility to arrange for any required eq of this type of equipment include: ospital beds, wheelchairs, alternat	rred to the Medicare beneficiary, it is the beneficiary's uipment service or repair.		
FOR INEXPE	NSIVE OR ROUTINELY PURCHASED	ITEMS:		
cannot exc • Examples o Ca blo	ceed the fee schedule purchase an of this type of equipment include: nes, walkers, crutches, commode			
I select the	2:			
Purchase (Option	Rental Option		

Date



Patient Documentation Check List

I acknowledge that I have received a Customer Information Handout and have been Instructed and understand:

My "Bill of Rights" and my responsibilities	
My right to refuse Treatment	
How to reach Chino Medical Supply	
	and and an annualization to me
How to safely use and operate the equipn	nent and or supplies given to me
Patient Survey	
Patient Plan of Care (if Applicable)	
Restriction Agreement (1f Applicable)	
30 Medicare Standards	
Assignment of Benefits	
HIPPA Form	
Warranty Information	
Capped Rental Form	
Intake Form	
Communication Log	
Copies of Insurance Cards	
Patient Signature Patient Name	
Relationship Date	
Patient Signature	Patient Name
Relationship	Date
Technician:	