

12422 Central Ave.
 Chino CA 91710
 9-464-1500 Fax 909-464-1570



Order Intake																			
Order Received	Order Dispensed																		
Date:	Date: Time:																		
By:	Rep:																		
Patient Information:	Subscriber (If different from patient/facility)																		
Name:	Name Facility:																		
Address:	Address:																		
City/State: Zip:	City/State: Zip:																		
Phone:	Phone:																		
Insurance Information:																			
	Secondary:																		
ID#																			
Address:	Address:																		
City/State: Zip:	City/State: Zip:																		
Phone:	Phone:																		
Clinical Information:																			
DOB:																			
Action Taken:																			
<table border="0"> <tr> <td>Representative notified</td> <td>Insurance Information Obtained</td> <td>CMN Sent</td> <td>Medicare Elig Cleared</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Pre-authorization done</td> <td>Patient/Facility Contacted</td> <td>CMN Received</td> <td>Medi Cal/IEHP/Molena</td> <td>Y</td> <td>N</td> </tr> <tr> <td colspan="6">Same or Similar Cleared Y N</td> </tr> </table>		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 Cleared Y N					
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 Cleared Y N																			
Physician Information:																			
Name:	Phone:																		
Address:	City/State:																		
NPI:	Lic#																		

Advanced Beneficiary Notice



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.

_____ **FOR CAPPED RENTAL ITEMS:**

- Medicare will pay 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), bed side rails and traction equipment.

I select the:

Purchase Option _____

Rental Option _____

Beneficiary Signature

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
- _____ How to safely use and operate the equipment 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: _____