12422 Central Ave.

Chino CA 91710

9-464-1500 Fax 909-464-1570

CHINO MEDICAL SUPPLY
"Best Quality For A Better Life."

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:	
Action Taken:	

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#

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Advanced Beneficiary Notice

Members Name:

NOTE: You need to make a choice about receiving these health care items.

After reviewing our records, it appears that your health plan insurance will not pay for the total cost of the item (s) described below. Most health plan insurances do not pay for all of your health care costs and generally only pay for covered items and services that are considered Standard Medical Benefits. The fact that your insurance may not pay for the item does not mean that you cannot receive it. You also have the option to pay for these item (s) if you choose to.

Items	**Insurance Allowable**	**Members Share**
		0.00
		0.00
		0.00
Totals	0.00	0.00

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items, knowing that you might have to pay at least part or all of it yourself. Before you make a decision about your options you should read this entire notice carefully and feel free to ask any further questions:

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 my insurance does pay for all the services you will refund any over payments,

x	**x**
Date	Signature of member or person acting on the member's behalf

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:_____

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