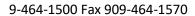
Chino CA 91710





Order Intake				
Order Recei	ived		Order Dispensed	
Date:			Date:	Time:
Ву:			Rep:	
Patient Info	rmation:		Subscriber (If differ	rent from patient/facility)
Name:			Name Facility:	
Address:			Address:	
City/State:	Zip:		City/State:	Zip:
Phone:			Phone:	
Insurance Ir	nformation:			
			Secondary:	
ID#				
Address:			Address:	
City/State:	Zip:		City/State:	Zip:
Phone:			Phone:	
Clinical Info	rmation:			
Action Take	n:			
	Downsontation and find	Insurance Information Obtained	CMAN Comb	Medicare Elig Cleared Y N
	Representative notified			
	Pre-authorization done	Patient/Facility Contacted	CMN Received	Medi Cal/IEHP/Molena Y N
Same or Similar Cleared Y N				
Physician In	formation:			
Name:			Phone:	
Address:			City/State:	
NPI:		-	Lic#	



Advanced Beneficiary Notice

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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
Totals		

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	Х
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

that I received as being either a capped rental or an inexpensive or routinely purchase item.				
FOR CAPPED RENTAL ITEMS:				
 equipment is transferred to the Medicare beneficing After ownership of the equipment is transferred to the responsibility to arrange for any required equipment Examples of this type of equipment include: 	to the Medicare beneficiary, it is the beneficiary's ent service or repair. essure pads, air-fluidized beds, Nebulizers, suction pumps,			
 cannot exceed the fee schedule purchase amount Examples of this type of equipment include: Canes, walkers, crutches, commode chairs 	ented; however the total amount paid for monthly rentals			
I select the:				
Purchase Option	Rental Option			
Beneficiary Signature				



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:	