PEAKS & PLAINS, INC.

Date:

DME, DIABETIC SHOE AND ORTHOTIC INTAKE FORM
BENEFICIARY INFORMATION

Name:	**Date of Birth:**
Facility Name / Patient Home:	**□ Male □ Female**
Address:	
City, State, Zip	
Facility Telephone #:	**Facility Fax #:**
Contact at Facility:	
Emergency Contact other than in home:	**Emergency Phone #:**
Name of POA or Responsible Party:	
Address:	**Responsible Party Phone:**
City, State, Zip	
Admit Date (Medicare Part B takes over after first 100 days):	
Patient Height: **Patient Weight:**	
PRODUCT DESCRIPTION:	
Has the beneficiary ever received same or similar equipment?	□ Yes □ No WHEN:
DIAGNOSIS: (Diabetes Mellitus must be coded to 5th digit)	**ICD-9 Code:**
Measurements: **□ Right □ Left**	

BENEFICIARY INSURANCE INFORMATION

PATIENT MEDICARE #:	□ Yes □ No
Is beneficiary enrolled in a Medicare HMO/managed care program?	□ Yes □ No
HMO / MANAGED CARE:	
MEDICAID #: (if no coupon available)	□ Yes □ No
SUPPLEMENTAL INSURANCE:(must have complete address)	□ Yes □ No
Name:	
Address:	
City, State, Zip	
Telephone:	

POLICY holder name: **POLICY ID#:**

(It could be the spouse) **(Including any letters that may precede or follow ID#)**

Sales Representative:

PLEASE FILL IN AND SIGN REVERSE SIDE

ORDERING PHYSICIAN INFORMATION

Full Name:

Address:

City, State, Zip

Telephone: **Fax#:**

FOR OFFICE USE: Physician U-PIN #: Physician Medicaid #:

How did you hear about us?

In order for us to bill Medicare and/or other insurance for the items marked below, this form must be completed, signed and returned. Without this signed form in our files, we cannot send to you the products that your physician prescribed.

By my signature below, I authorize and/or acknowledge the following:

(A) Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Peaks and Plains, Inc.
(B) Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
(C) Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns any information needed to determine these benefits or the benefits payable for related services.
(D) Peaks and Plains, Inc. to obtain medical or other information necessary in order to process my claims(s), including determining eligibility and seeking reimbursement for the item(s) indicated below.
(E) Peaks and Plains, Inc. to contact me by telephone or mail regarding my order for the item(s) indicated below.
(F) Receipt of Peaks and Plains, Inc. "Notice of Privacy Practices" which provides a description of uses and disclosures of protected health information; and, if appropriate, the "Supplier Standards," the regulations regarding Medicare covered supplies. I have been given a copy of the "Client Bill of Rights" and, if appropriate, "How to Report a Grievance" for Medicare beneficiaries.
(G) Receipt of Peak and Plains, Inc. "Equipment Warranty Information Form" which provides a description that Peaks and Plains, Inc. honors the manufacturer's warranty under applicable law.
(H) Receipt of Peak and Plains, Inc copies of Instructions for use and care of Product purchased has been received.

Item(s): _____
This Assignment of Benefits is effective for the above-referenced item(s) supplied to me by Peaks and Plains Medical, Inc. on or after_____/____/_____.

I agree to pay all amounts not covered by Medicare, Medicaid, Medicare Supplemental or other insurance and for which I am responsible.

_____ Date Signed:_____
PATIENT SIGNATURE
If patient unable to sign, signature of representative:_____

Relationship of representative to patient:_____

Address of representative:_____
Responsible Party must have POA or Authority in Writing to Sign on Behalf of the Patient

REASON PATIENT IS UNABLE TO SIGN_____

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PHONE: 1-800-585-4201
FAX: 1-800-886-3122
E-mail: amber@peaks-plains.com

A copy of the patient's Medicaid, Medicare and other insurance cards need to be sent with this order.

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