

Order taken by: _____ Date: _____

Referral Person Calling in Order: _____ Telephone: _____

BENEFICIARY INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ Sex: Male Female

City, State, Zip: _____ Weight: _____ Height: _____

Telephone: _____ Medicare #: _____

Name of Legally Responsible Representative: _____

Relationship to Beneficiary: _____

Street Address: _____

City, State, Zip: _____ Telephone: _____

ORDERING PHYSICIAN INFORMATION

Name: _____ NPI #: _____

Street Address: _____ Telephone: _____

City, State, Zip: _____

QUESTIONS FOR THE BENEFICIARY

Has the beneficiary ever received the same or similar supplies/equipment? Yes No

If yes, list equipment/supplies: _____

Who was it purchased or rented from? _____

Date purchased, or if rented, how many months? _____ Date of past set-up: _____ Date equipment was returned: _____

Why was the item returned to original supplier? _____

Is the item being replaced? Yes No

Is there a new medical necessity? Yes No

Describe condition for previous need: _____

Describe new/changed condition: _____

Is the beneficiary enrolled in a Medicare HMO/managed care program? Yes No

Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)? Yes No



QUESTIONS FOR THE SUPPLIER

(If providing repairs on equipment, obtain the following information for the item being repaired)

Manufacturer: _____ Model Name or #: _____ Serial #: _____ Purchase Date: _____

Reason or nature of repairs: _____

Do you have medical necessity to file for repairs? Yes No

Does beneficiary meet criteria for item being repaired? Yes No

Questions for the Supplier, continued . . . _____

Where will the item be used? _____

SIGNATURE

Beneficiary Signature: _____ Date Signed: _____

This is just a suggested intake form and suppliers can model one to fit their particular type of business. For example, if you are providing oxygen, there may be certain questions you need to ask regarding oxygen patients, or, if you are providing wheelchairs, there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in any way replace obtaining an Advance Beneficiary Notice (ABN), if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the DME MAC Jurisdiction C Supplier Manual, Chapter 3, for information about same/similar equipment and ABNs and the Limitation of Liability section in Chapter 6, for more information.