DME & Pharmacy Proof of Delivery-Patient Instruction-Insurance Billing

Circle A Pharmacy

Name:	Date of Visit
Address:	☐ Initial Delivery
Phone:	☐ Follow-up
Alternate Contact:	Phone:

HOME ENVIRONMENT/SAFETY ASSESSMENT ☐ **NA – NOT DELIVERED TO HOME**

Discuss all appropriate factors and √ if in order ☐ **SAFETY** Uncluttered pathways Fire safety assessed Safe operating equipment Cords & Adapters Safe environment Pt/CG understands safety issues Bathroom assessed Safe electrical outlet Area Rugs Getting in & out of device	**APPROPRIATE FOR HOME** ☐Yes ☐No ☐Alert & Understands INSTRUCTIONS ☐Pt. Confused/ caregiver instructed ☐ Return Demonstration by patient ☐ DME item was checked and in good working order (Confirmed supplies have not expired)
OTHER HOME CARE SERVICES:	**Phone:**

EQUIPMENT

Delivery document including the date of delivery, company information, patient information, product information (manufacturer, model, quantity, and description), patient paperwork provided, and any identifying number (serial/lot) in addition to patient and delivery person's signature (or tracking number receipt) should be used to maintain proof of delivery **YOU CAN USE A SEPARATE FORM FOR PROOF OF DELIVERY**

Make, Model & Description:	Lot/Serial #
Amount Billed to Insurance:	Approximate Co-Pay:

√ TYPE OF PRODUCT – MODIFY FORM TO LIST WHAT YOU WILL EXIST PROVIDING

☐ Ambulatory products	☐ Std Wheelchair	☐ Patient Handling Products
☐ Bath & Safety Products	☐ Power Wheelchair	☐ Transfer Aids
☐ Beds/Patient Room Products	☐ Orthotics	☐ Diabetic Testing Supplies
☐ Seating Products		☐ TENS Units
☐ Scooter		☐ Other _____

ADDITIONAL INSTRUCTIONS

The following has been given to and/or discussed with the patient/caregiver:

Scope of Services. Privacy Notice Patient Rights & Responsibility

Patient Informed of charges. ❑ **Patient Agreement (Insurance AOB or NA) 2nd signature**

Documentation Instructions for use – User Manual

Patient Satisfaction Survey.

Medicare Supplier Standards Capped Rental/Purchase Letter (Medicare insurance only)

Warranty Information

Complaint Protocol: If you are unhappy with the services provided by this company, please call 818-946-1060 We will respond within 5 calendar days. In the event your complaint is not resolved to your satisfaction you can contact our accrediting organization The Compliance Team at www.thecomplianceteam.org or by calling 1-888-291-5353.

ADDITIONAL NOTES:

FOLLOW UP/DISCHARGE

FOLLOW-UP VISIT RECOMMENDED ☐ FOLLOW-UP BY PHONE & AS NEEDED ☐

Signatures below confirm all applicable information was given to the patient

A copy of this form has been given to the patient/caregiver ☐

(If Patient unable to sign; authorized person complete. If person does not live with patient list contact information)

PATIENT SIGNATURE:	Print name/Relationship/WHY the patient can't sign:
EMPLOYEE'S SIGNATURE:	Date: