

Orthotic & Prosthetic Lab, Inc.

(This information is necessary for our files and will be considered confidential)

Pt ID#: _____

Patient's Full Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex M / F Birthdate _____ E Mail Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Social Security # _____ Marital Status: Minor/Single/Married/Widowed/Divorced

If under 18, guardian name _____

Guardian SS# _____ **Guardian's date of birth:** _____

*Emergency Contact _____ Phone # (____) _____

Referring Physician _____ Diagnosis/Nature of Injury _____

Primary Care Physician _____

Are you a diabetic? Y / N Do you take insulin? Y / N Name of diabetic Dr: _____

Do you have a history of any of the following symptoms (circle all that apply): amputation, foot ulcerations, callus, peripheral neuropathy, foot deformity or poor circulation

PRIMARY INSURANCE

Name of Insured _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____ Cell # _____

Relationship to Patient: Self /Spouse/Parent/Other Name of Insurance _____

Insurance ID# _____ Ins. Group # _____

Place of Employment _____ Employer Phone # _____

SECONDARY INSURANCE

Name of Insured _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____ Cell # _____

Relationship to Patient: Self /Spouse/Parnt /Other Name of Insurance _____

Insurance ID# _____ Ins. Group # _____

Place of Employment _____ Employer Phone # _____

WORKERS' COMPENSATION

Employer at time of injury _____ Phone # (____) _____ Date of Injury _____

Workers' Comp. Insurance Name _____

Phone # (____) _____ Claim # _____ Case Manager _____

AUTOMOBILE ACCIDENT

Insurance Company or Agency Name _____

Claim/Case # _____ Date of Accident _____

Insurance Contact _____ Phone # (____) _____

(Patient Name)

(Pt. ID #)

Assignment of Benefits / Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Orthotic & Prosthetic Lab, Inc. for any covered services furnished by Orthotic & Prosthetic Lab, Inc. I agree to pay to Orthotic & Prosthetic Lab, Inc. the deductible and/or coinsurance on my claim or any of my dependent(s). I further agree that should the amount be insufficient to cover the entire orthotic or prosthetic expense, I will be responsible for payment of the difference, and if the nature of the disability be such that it is not covered by the policy, I will be responsible to Orthotic & Prosthetic Lab, Inc. for payment of the entire bill.

I also understand that telephone inquiries to my insurance company **ARE NOT** a **guarantee of coverage/benefits**. We (Orthotic & Prosthetic Lab, Inc.) have attempted to estimate your balance due; however, after review by your insurance company, you may owe an additional amount.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

By checking this box and signing below, I acknowledge receiving a copy of Notice of Privacy Practices (NPP)

Patient or Representative Signature: _____ **Date:** _____

If Representative, please complete below.

Printed Name: _____

Address: _____

Relationship to Patient: _____ Reason for Patient's Inability to Sign: _____

For Notice of Privacy practices only, describe the Personal Representative's authority to act on behalf of the patient:

Please list any individuals we may speak to or release information to:

I authorize the following individuals, including myself to have access to information regarding self/patient.

Please print name relationship to patient

Please print name relationship to patient

Signature: _____ Date: _____

Authorization for Release of Protected Health Information
Patient Identification



Name: _____ DOB _____

Address: _____ SS# _____

Information is to be released by _____

Information is to be released to _____

Street address _____

Street address _____

City, State and Zip Code _____

City, State and Zip Code _____

Telephone _____

Telephone or Fax _____ (please check if to be sent to fax)

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE

From (date) _____

to (date) _____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED

Complete Health record ___ Billing ___ Diagnosis/Treatment Codes ___ Discharge Summary ___ Lab Results ___ Xray results ___

Other (specify) _____

Purpose of request _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release (check one)

YES _____ NO _____

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Records Department or other department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date _____ or 90 days from date of signature, unless otherwise specified.

RE-RELEASE

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

Your provider will not deny treatment if you do not sign this form. BY SIGNING BELOW, YOU AUTHORIZE YOUR PROVIDER, IDENTIFIED, TO RELEASE YOUR PROTECTED HEALTH INFORMATION SPECIFIED ABOVE AS WELL AS AGREE TO PAY ANY FEES THAT MAY APPLY.

SIGNATURE _____ DATE _____

AUTHORITY TO SIGN (IF NOT PATIENT) _____ WITNESS _____

Identity of requestor verified via: photo ID: ___ matching Signature: ___ other, specify _____ ID verified by _____

Patient Name: _____ Patient ID #: _____

MEDICARE PATIENT HISTORY

If Medicare eligible you must answer all the following questions.

1. Are you enrolled in a Medicare HMO (ex. Medicare Complete/Advantra)? Yes/No
If yes: Medicare HMO ID# _____ Group # _____
If no: Medicare ID# _____
2. In the last year have you resided in another state? Yes/No
If yes: what state _____
3. Are you or your spouse currently employed? Yes/No
4. Do you carry insurance through that employer? Yes/No
5. If yes: Name of Insurance _____ ID# _____

Are you a diabetic? Yes/No _____

Are you insulin dependent? Yes/No _____

Do you have a history of any of the following symptoms (circle all that apply): amputation, foot ulcerations, pre-ulcerative callus, peripheral neuropathy, foot deformity or poor circulation

Name & phone # of diabetic doctor: _____

Have you ever received similar supplies/equipment? Yes/No _____

If yes, what item are we replacing _____

If yes, why being replaced _____

If yes, who was it purchased from _____

If yes, date of purchase _____

If yes, name of insurance carrier billed _____

If patient answered yes or is unsure to above need to check the 3/5 yr rule and obtain signed ABN waiver.

By checking this box and signing below, I acknowledge receiving a copy of the Medicare Supplier Standards.

Patient Signature : _____ **Date:** _____

Patient Name: _____
Patient ID # : _____

Patient Contact Protocol

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individuals office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- Primary Phone:** _____
- O.K. to leave message with detailed information
 - Leave message with call back number only
 - O.K. to talk to Spouse and leave detailed information

- Secondary Phone:** _____
- O.K. to leave message with detailed information
 - Leave message with call back number only

- Written Communication**
- O.K. to mail information to home address
 - O.K. to e-mail (must provide e-mail address) _____

- Other:** _____

Patient or Guardian Signature _____ Date _____

Print Name/Relationship _____ Birthdate of Patient _____

ORTHOTIC AND PROSTHETIC LAB, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact: our Privacy Contact who is Tom Malone 314-968-8555

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day to day operations. This Notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with this Notice of Privacy Practices and applicable law;

Give you this Notice of our legal duties and our privacy practices; and

Abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Your protected health information may be used and disclosed by your Orthotist or Prosthetist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of O & P Lab, Inc.

Following are examples of the types of uses and disclosures of your protected health care information that O & P Lab, Inc is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to the physician that referred you to us. We will also disclose protected health information to other health care providers who may be treating you when we have the necessary permission from you to disclose your protected health information.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine whether your plan will cover the device.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of O&P Lab, Inc. These activities include, but are not limited to, quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for this O&P Lab, Inc. Whenever an arrangement between O&P Lab, Inc and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your Practitioner is ready to see you.

Marketing and Health Related Benefits and Services: We may also use and disclose your protected health information for other marketing activities. For example, we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Sale of the Practice: If we decide to sell this practice or merge or combine with another practice, we may share your protected health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing. You understand that we can not take back any use or disclosure we may have made under the authorization before we received your written revocation, and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Either With Your Agreement or the Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Practitioner may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to object.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans: If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the O&P Lab, Inc's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related illnesses and injuries.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility. O&P Lab, Inc and your Orthotist or Prosthetist created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your Practitioner uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. For example, you may not inspect or copy psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified protected health information defined by law. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as

described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Practitioner is not required to agree to a restriction that you may request. If the **Practitioner** believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your **Practitioner** does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your **Practitioner**. You may request a restriction by submitting your request in writing to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your Practitioner amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your **Practitioner** uses for making decisions about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact, and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that:

1. Was not created by us, unless the person that created the information is no longer available to amend the information;
2. Is not part of the protected health information kept by or for us;
3. Is not part of the information you would be permitted to inspect or copy; or
4. Is accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than six years and cannot include any date before April 14, 2003. You may request a shorter timeframe. Your request should indicate the form in which you want the list (i.e., on paper, etc). You have the right to one free request within any 12 month period, but we may charge you for any additional requests in the same 12 month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Contact, Tom Malone at (314) 968-8555 or by e-mail at tmalone@oandplabinc.com for further information about the complaint process.

4. CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in this Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of your next appointment.

This notice was published and becomes effective on April 14, 2003.

ORTHOTIC & PROSTHETIC LAB INC.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Orthotic & Prosthetic Lab, Inc Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Orthotic and Prosthetic Lab's** health care operations. The Notice of Privacy Practices also describes my rights and Orthotic and Prosthetic Lab, Inc's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the reception area of the office.

Orthotic and Prosthetic Lab, Inc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly; or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://ecfr.gpoaccess.gov>. Upon request we will furnish you a written copy of the standards.