YOUR 100% SATISFACTION IS OUR ONLY GOAL!
CALLER IS SELF: ☐Yes ☐No

NAME/RELATIONSHIP:	DATE:

Patient Name:	Phone:	Cell/Alt Contact:

Address: City:	State, ZIP:	Email/Fax

Weight:	Height:	Age:	Date of Birth	*:Mediare Number*

Medicare(HMO)? ☐Yes ☐No *Replacing equipment less than 5 years?* ☐Yes ☐No Patient Safety/Privacy Pack: ☐Yes ☐No	Co-Pay Insurance? ☐Yes ☐No Can You Pay Co-Pay? ☐Yes ☐No If no, Complete "Co-Ins. Calculation Form"	*Physician Name:*	*Physician Contact Information*

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS

I,______________________________ , the undersigned, understand and agree that I am receiving items of durable medical equipment (Equipment) from **AAMCARE ELECTROPEDIC** (Supplier) on Medicare Assignment. This means I am being provided Equipment before my insurance has been billed.
I have been advised by the Supplier that Medicare will only pay for Equipment that Medicare determines is medically necessary. If Medicare does not pay for the Equipment, I will be responsible for its return to the Supplier; or I can choose to purchase the Equipment at full price. I also understand and agree that I am responsible for any abuse or neglect to the Equipment. I also understand that being enrolled in an HMO during the time of billing will be cause for automatic denial of payments. **I hereby authorize payment of medical benefits to be made directly to AAMCARE ELECTROPEDIC. I further authorize the release of any medical information necessary to determine the extent of third party coverage and for processing insurance claims on my behalf.**

Patient or authorized party's signature:	Date:	Print Name:

Reason Patient is unable to sign:	Reason Patient is unable to sign:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information: Name Address DOB

Information to be Released: Prescription for Durable Medical equipment, Inc. chart notes, Face to face and Progress notes
Authorized to Receive Protected Information: Aamcare Electropedic, 907 Hollywood Way, Burbank CA 91505
Purpose or need for disclosure: Payment of Insurance Claim
This authorization will remain in effect until the above disclosure has been completed

Patient or authorized party's signature:	Patient's Medicare (HICN) Number:	Date:	Print Name:

If not patient, Relationship to patient:	Reason Patient is unable to sign:

DOCUMENTATION FROM DOCTOR: Prescription must be received prior to delivery of product. *Prescription must have Description of the item, Beneficiary's name, Physician's name and Start date of the order. Medical Records/Chart Notes should include: Duration of the patient's condition, Clinical course (worsening or improving), Prognosis, Nature and extent of functional limitations, Other therapeutic interventions and results, Past experience with related items, 7-Element Order. Order includes: Beneficiary name, Item ordered, Date of face-to-face examination, Diagnosis/condition relating to need for item, Length of need, Physician signature, Signature date

Fax all documentation to (800)735-1480.

RX: Dated & Signed* ☐Yes ☐No	**Face to Face < 45 days**: POV's Req'd ☐Yes ☐No	**7 Elements:** POV's Req'd ☐Yes ☐No	**Chart Notes**: Hospital Bed & POV's Req'd ☐Yes ☐No	**CMN-849:** Lift Chair Req'd ☐Yes ☐No

Qty	HCPCS Code	Description of Item, Make, Model & Serial Number	Price

ABN APPLICABLE: ☐Yes ☐No Must be on the approved CMS-R-131 form/ Note Non-Covered/Upgrade Items HERE

Qty	HCPCS Code	Description of Item, Make, Model & Serial Number	Price

Billing Services: Fax all documentation to (800)735-1480. Questions: (818)591-2770 Delores Keller

POWERED WHEELCHAIR/SCOOTER ONLY IN HOUSE EVALUATION

GENERAL	BEDROOM	BATHROOM	LIVING ROOM
Is residence a: ☐House ☐Mobile home ☐Apartment	Does power wheelchair fit through bedroom door? ☐Yes ☐No	Does power wheelchair fit through bathroom door? ☐Yes ☐No	Measurement of door by which patient enters room?
Width of narrowest doorway you will use:	Width of narrowest doorway you will use:	Is there room for power wheelchair in bathroom? ☐	Does the wheelchair fit through door? ☐Yes ☐No
Ramp to be built soon?: ☐Yes ☐ No	Floor Surface: Carpet ☐Hardwood ☐Tile ☐Other:	Floor Surface: Carpet ☐ Hardwood ☐Tile ☐Other:	Can the patient maneuver the wheelchair? ☐Yes ☐No

KITCHEN	HOME		
Measurement of door by which patient enters room with wheelchair:	Is there sufficient room throughout the patient's home to allow the patient to perform MRADLs using a motorized wheelchair? ☐Yes ☐No If no, why? ☐Insufficient space to turn ☐Other:	Is there sufficient room throughout the patient's home to allow the patient to perform MRADLs using a POV? ☐Yes ☐No If no, why? ☐Insufficient space to turn ☐Other:	*I performed the Home Evaluation – Mobility assistive Equipment of the beneficiary's home. I observed the beneficiary maneuver the motorized wheelchair/POV without difficulty throughout the areas of the home in which the beneficiary will be performing mobility related activities of daily living.* **Tech Signature:** ______________________
Does the wheelchair fit through the door? ☐Yes ☐No			
Can the patient maneuver the wheelchair? ☐Yes ☐No			
Floor Surface: Carpet ☐Hardwood ☐Tile ☐ Other:			

SAFETY CHECKS: TECH & PATIENT *MUST* INITIAL

SAFETY CHECKS WHEELCHAIR/SCOOTER

Item	Tech	Patient	Item	Tech	Patient
Wheelchair/Pov Operational			Handling, Operation, Control		
Braking System /			Wheelchair Breakdown Transport		
Braking Function Tested			Tech. Support Phone # Sticker		
Batteries/Charger Operational/			Seat, Arm, Back, Patient Positioned		
Programmed Functions/ Programming Operational			Parts/Acc. Functional/Service		
Joystick Operations/Joystick Positioned			Battery Re-Charging & Handling		
Tires Checked					

SAFETY CHECKS HOSPITAL BED

Item	Tech	Patient
Hand Control Checked		
Electric Cord Checked		
Siderails Checked		
Electric Motors Checked		
Head & Footboard Motor Checked		
Manual Operation Checked		

SAFETY CHECKS LIFT CHAIR

Item	Tech	Patient
Electric Motors		
Clearance Checked		
Hand Control Checked		
Electric Cord Checked		

ACKNOWLEDGMENT OF DELIVERY & RECEIPT BY PATIENT

I authorize payment of Medicare (or other health insurance benefits) be made on my behalf be made to AAMCARE ELECTROPEDIC for items or services it furnished to me. I authorize the holder of medical or other information about me to release to the Center for Medicare and Medi-Cal Services and its agent or to any to other insurance carrier and any information needed to determine these benefits or benefits for related services.

I, the undersigned, have received the Medical Equipment as identified above and accept in good working condition.

I have been fully instructed in the use and operation of the above medical equipment. I witnessed all safety checks performed by the service technician and have been advised of the applicable warranties. I have been instructed in the use and safety of the medical equipment. I have been provided the name and telephone # of the AAMCARE ELECTROPEDIC and/or service technician to contact regarding the care, operation or service of the Medical Equipment. AAMCARE ELECTROPEDIC is not responsible for damage to the Power Wheelchair as a result of misuse, modification by me or my designee or moisture including but not limited to the control unit.

Aamcare Electropedic has provided the following:

DELIVERY TICKET, MANUFACTURER'S WARRANTY INFORMATION AND MANUAL, AAMCARE ELECTROPEDIC 'S EQUIPMENT WARRANTY, SERVICE AND REPAIR POLICY, HIPAA NOTICE OF PRIVACY PRACTICES, PATIENT'S BILL OF RIGHTS, AND SUPPLIER STANDARDS I acknowledge that I have received a copy of the Manufacturer's Warranty and Manual for equipment purchased; AAMCARE ELECTROPEDIC 's Delivery, Safety and Instruction Checklist; AAMCARE ELECTROPEDIC 's Warranty Service and Repair Policy; HIPAA Notice of Privacy Practices; Patient's Bill of Rights; and the Supplier Standards.

Patient or authorized party's signature:	Date:	Print Name:
If not patient, Relationship to patient:	Reason Patient is unable to sign:	

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