CUSTOMER INFORMATION CHECKLIST

Customer: _____

Equipment: _____

(Please Check Appropriate Items)

( ) Customer Information, Customer Complaints, Customer Rights and Responsibilities (See Separate Inserts)

( ) HIPAA Privacy Notice and Medicare Supplier Standards (See Separate Inserts)

( ) **Acceptance of Services**
I understand that by signing this agreement, I authorize provision of products and/or services to me by **DeanRosecrans**. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

( ) **Same or Similar Equipment** ☐ No ☐ Yes
If "No" is checked, I acknowledge that I have never received the same or similar equipment, as listed above, from another home medical equipment provider. If I have selected "Yes", then I understand that my insurance carrier may not cover the above named equipment and I may be asked to execute an Advance Beneficiary Notice.

( ) **Release of Information**
I hereby authorize release to **DeanRosecrans** any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize **DeanRosecrans** to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

( ) **Assignment of Benefits**
I authorize direct payment of insurance benefits by my insurance company to **DeanRosecrans**. In the event that my insurance carrier does not accept "assignment of benefits", I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to **DeanRosecrans** for payment of my bill.

( ) **Financial Responsibility**
I understand that I am responsible to **DeanRosecrans** for all charges not covered by my insurance. I recognize that in the event that my insurance company, employer, or any other third party payer refuses to pay purchase price(s) of the above items, or delays payment beyond 90 days of my receipt of items, or in the event that I have no insurance coverage or third party payer, that I will be responsible for said payments and will make prompt reimbursement within 30 days of notification by **DeanRosecrans** for all charges.

( ) **Review Printed Instructions for Use**
_____ Review printed safety precautions
_____ Explain customer's responsibility for routine maintenance, cleaning
_____ Give Company address, phone, and business hours
_____ Explain delivery options

Customer: _____ Date: _____

Relation: _____ Reason: _____

Customer Service Representative_____ Date: _____

DeanRosecrans does not offer an on call service. If it is after hours, please call toll free (800) 237-3699 and leave a message. Your call will be returned the next business day.

PLACE IN SELF ADDRESSED ENVELOPE AND RETURNED

Revised 04/22/2014

DeanRosecrans

Access, Delivery and Service

Customer: _____

Equipment: _____

	Y	N	N/A
1. Equipment/Supplies was delivered in a timely manner.	____	____	____
2. Equipment/Supplies was ready for patient use upon delivery.	____	____	____
3. Received and understood instructions on proper application and use of equipment/supplies.	____	____	____
4. Feels confident to operate/use equipment/supplies.	____	____	____
5. Received information on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	____	____	____
6. Response to my questions, problems, concerns were addressed in a timely manner.	____	____	____
7. Satisfied with the equipment/supplies.	____	____	____
8. Satisfied with the service. Would recommend to others.	____	____	____

Comments:

_____
_____
_____
_____
_____
_____

Revised 04/22/2014

DME Instruction Delivery/ Delivery Ticket

Name: _____ Initial Delivery Date: _____

Address:_____ Follow-up Date: _____

_____

City State Zip

Phone: _____

Alternate Contact: _____

Alternate Phone: _____

Equipment

Type of Product:		Quantity:
▪*90 Foam Filters:*	*thin thick*	▪ *Servox batteries:*
▪*24x3 Foam Strip :*	*thin thick*	▪ *Cloth covers:*
▪*6-9x24 Foam Sheets:*	*thin thick*	▪ *Shower collars:*
▪ *9 Foam stoma covers:*	*thin thick*	▪ *Replacement tape: 3*

Romet Electrolarynx
Servox Electrolarynx

Est Prime Ins. payment	$
Est. Supplement Ins amt	$
Est. You will pay	$

Additional Instructions

The following has been given to the patient **(located in instructions, white packet enclosed with order or new unit, OR found on the customer information checklist sheet):**

- ☐ Rights & Responsibilities
- ☐ Purchase Information
- ☐ Service Availability
- ☐ Medicare Supplier Standards
- ☐ Warranty Information
- ☐ Privacy Notice
- ☐ Cleaning and Maintenance
- ☐ Equipment Instructions
- ☐ Complaint Process (how it is reviewed/resolved)

I have read, received and/or been instructed in detail on the items checked above.

(If patient unable to sign; authorized person complete)

Patient Signature:	Family/Guardian: Print name/relationship/reason patient is not able to sign:
Employee Signature:	Signature:

Revised 04/22/2014

DeanRosecrans
PO Box 553
Newtown Square, PA 19073
1-800- 237-3699

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold by **DeanRosecrans** carries a 1-year manufacturer's warranty. **DeanRosecrans** will repair or replace, free of charge, Medicare-covered equipment that is under warranty. However abuse, neglect, lost of components, as well as any modifications or alterations by the owner or an agent voids this warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage on the product I have received.

_____ _____

Beneficiary's Signature Date

Revised 04/22/2014

WELCOME TO DEANROSECRANS

DeanRosecrans is a privately-owned company dedicated to providing lanryngectomee patients/clients with quality healthcare supplies. We specialize in the sale of laryngectomee stoma supplies and artificial larynx batteries. We are a mail-order company only and do not see any patients at our facility.

DeanRosecrans prides itself on its staff of highly motivated customer service representatives, people who know and understand your needs and respond to them in a personal and friendly manner. All our staff works together as a team to provide the finest patient care available.

At **DeanRosecrans**, we accept only those patients/clients whose health care can be properly met by the services we offer and by the area we serve. We deliver all our products and services to customers in the United States. A partial listing of our supplies

- laryngectomee stoma supplies
- Artificial Larynx batteries

DeanRosecrans is proud to let you know that we offer:

Delivery Services
Reimbursement Assistance

We are pleased that you have chosen **DeanRosecrans.** You can be assured that through caring, concern, and dedication, we strive to achieve a higher quality of life for the patients/clients we serve.

Please retain this patient copy for your records.

Revised 10/31/2013

DeanRosecrans

OUR MISSION AND PURPOSE

The founder of DeanRosecrans, a laryngectomee himself, created his Company in 1972 to improve the quality of life for laryngectomy patients. Our company, named for its founder, offers quality stoma supplies, including but not limited to filters and replacement batteries for Servox. We always strive to provide excellence in our business.

CUSTOMER INFORMATION

Our Customer Service hours are 8:00 a.m. to 4:00 p.m. Eastern Standard or Day Light Savings Time, Monday through Friday. Our normal company office hours are 9:00a.m. to 5:00p.m. Eastern Standard or Day Light Savings Time, Monday through Friday. A voice message system will answer the Company's phones after normal business hours or if Customer Service is helping another caller. However, most services will be performed during normal service hours. If your call is an emergency and cannot wait until normal business hours, it is suggested that the customer or caregiver dial "911" for professional emergency services.

CUSTOMER COMPLAINTS

Any customer who feels his/her rights have been denied, who desires further clarification of rights, or who desires to lodge a complaint or express contentment with any aspect of service or equipment, including concerns about patient safety and the risk of falls, should contact us through our main telephone number, without fear of reprisal by the Company or by any of its employees. If the issue cannot be resolved via a telephone call with a customer service representative, the matter will automatically be forwarded to the general manager. In the event your complaint remains unresolved with DeanRosecrans; you may file a complaint with our Accreditor, The Compliance Team via phone 1-888-291-5353 or through their website (exemplaryprovider.com).

CUSTOMER RIGHTS – YOU HAVE THE RIGHT TO:

- Be given timely, appropriate, and quality professional home care services without discrimination.
- Be provided with proper products and services as ordered by a qualified health care professional.
- Receive products in proper operating condition according to the manufacturer's specifications.
- Receive fair treatment, including honoring cultural, spiritual, and personal preferences.
- Request a detailed explanation of your bill for products and services.
- Be communicated with in a way that you can reasonably understand.
- Refuse equipment and services, accepting full responsibility for that refusal.
- Choose your provider of home care services.
- Be assured of confidentiality, to review your records, and to approve or refuse the release of records.
- Have competent and qualified people carry out the services for which they are responsible.
- Voice your grievances and recommend changes without fear of reprisal.
- Report concerns about patient safety without fear of reprisal.
- Be given reasonable notice of discontinuation of service.

CUSTOMER RESPONSIBILITIES – IT IS YOUR RESPONSIBILITY TO:

- Dial "911" whenever a life threatening medical emergency arises.
- Provide complete and accurate information regarding your medical history and billing information.
- Comply with your physician's orders and plan of care.
- Use and care for the equipment provided and not allow use by anyone other than the authorized patient.
- Contact us about any equipment malfunction or defect, and allow our staff to correct the problem.
- Advise us of any changes in your status, including address, medical condition, and billing information.
- Assume payment responsibility for services not covered by your insurance carrier, except when not allowed by law.
- Maintain a safe home environment for the proper utilization of equipment.
- To report to us any concerns about patient safety or occurrences of patient falls.
- Pay for the replacement costs of any equipment damaged, destroyed, or lost due to misuse, abuse, or neglect.
- **The Customer Information Checklist, attached survey, and the delivery ticket must be filled out, signed and returned to DeanRosecrans. DeanRosecrans will be unable to service your ORDERS until this is obtained from you.**

SHIPPING INFORMATION

- Shipment & Handling cost is flat rate of $7.50 for U.S. Priority Mail Shipping. For guaranteed two day shipping by UPS, we charge $50, one day we charge $75.00. Free standard shipping is included (U.S. Priority Mail) on orders totaling $50 or more after discounts.
- If no foam THICKNESS is marked, THIN will be shipped, be sure to mark the correct thickness.
- We do not accept returns. Please verify that you have completed the order form correctly. If the mistake is ours, please let us know and we will send a replacement.

My signature on the Customer Information checklist indicates I have received and understood all of the above.

Please retain this patient copy for your records.

Revised 10/31/2013

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 and cannot contract with an individual or entity to provide licensed services.
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. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from 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. This standard requires that the location is accessible to the public and staffed during posted hours of business, with visible signage. 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 must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
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 directly, or through a service contract with another company, 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 supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government 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 implementing 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 of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date - October 1, 2009*
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. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date- May 4, 2009*
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 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

DeanRosecrans

MEDICARE DMEPOS ESTANDARES PARA SUPLIDORES

Nota: Esta lista es una versión abreviada de los estándares todo suplidor de Medicare DMEPOS debe reunir para obtener y retener sus privilegios para facturación. La lista completa de éstos estándares, está en 42 C.F.R. pt. 424, sec 424.57(c).

1. El suplidor deberá cumplir con toda licencia aplicable del Gobierno Federal y Estatal y con todo requerimiento regulatorio, y no podrá contratar a un individuo o entidad para proveer esos servicios que requieran licencia.
2. El suplidor deberá proveer información completa y actualizada en la solicitud para suplidor de DMEPOS. Cualquier cambio de ésta información deberá ser reportada al National Supplier Clearinghouse en 30 dias.
3. Una persona autorizada (alguien cuya firma ate a la compañía) deberá firmar la solicitud para obtener privilegios de facturación.
4. El suplidor dispensará las recetas/órdenes de su propio inventario o deberá tener un contrato con otras compañías para la compra de los artículos necesarios para dispensar las recetas/ordenes. El suplidor no podrá tener contratos con ninguna entidad que esté excluída del programa de Medicare, cualquier programa de salud Estatal, o de los programas Federales de procuramiento y no procuramiento.
5. El suplidor deberá informar a los beneficiarios de que pueden alquilar o comprar equipo médico durable económico o rutinariamente comprado, y de la opción de compra de los equipos alquilados una vez que lleguen a su término de alquiler.
6. El suplidor deberá notificar a los beneficiarios de la cobertura de las garantías y honrar toda garantía aplicable bajo la ley Estatal y reparar o remplazar sin costo alguno, todo artículo cubierto por Medicare.
7. El suplidor deberá mantener un local físico en un lugar apropiado. Este estándard requiere que el local sea accesible al público y esté atendido durante las horas de operación. El local deberá medir por lo menos 200 pies cúbicos y tener espacio para guardar los expedientes médicos.
8. El suplidor deberá permitirle a CMS, o a sus agentes, que conduzcan inspecciones, para asegurar que el suplidor esté en cumplimiento con éstos estándares. El local del suplidor deberá ser accesible a los beneficiarios durante horas de negocios razonables y deberá mantener un letrero visible incluyendo las horas de operación.
9. El suplidor debe mantener una línea de teléfono para el negocio la cual esté registrada bajo el nombre del negocio en el directorio local, o un número sin costo, disponible a través de la operadora. El uso exclusivo de un beeper, de una grabadora, de un servicio de contestadora o de un teléfono celular durante las horas de operación, está prohibido.
10. El suplidor debe tener seguro comprensivo de riesgo y responsabilidad por una cantidad de por lo menos $300,000 que cubra los dos, el negocio y los clientes y empleados del suplidor. Si el suplidor manufactura sus propios artículos, éste seguro debe también cubrir riesgo y responsabilidad del producto y la operación en su totalidad.
11. El suplidor debe estar de acuerdo en no iniciar contacto telefónico con beneficiarios, con algunas excepciones. Este estándard les prohíbe a los suplidores contactar a los beneficiarios de Medicare basados en alguna receta médica verbal a menos de que le aplique alguna excepción.
12. El suplidor es responsable de entregar y explicar a los beneficiarios cómo usar todo artículo cubierto por Medicare, y mantener prueba de entrega.
13. El suplidor debe contestar preguntas y responder a toda queja que los beneficiarios tengan, y mantener documentación de dichos contactos.
14. El suplidor debe dar mantenimiento y remplazar sin costo alguno o reparar directamente, o a través de un contrato de servicio con otra compañía, artículos cubiertos por Medicare que el suplidor haya alquilado a los beneficiarios.
15. El suplidor debe aceptar devoluciones de artículos de baja calidad o inadecuados de los beneficiarios (artículos cuya calidad sea inferior a la establecida para dicho artículo, o artículos que son inapropiados para el beneficiario en el momento de haber sido medidos y alquilados o vendidos).
16. El suplidor debe revelar éstos estándares para suplidores a cada beneficiario a quien provee artículos cubiertos por Medicare.
17. El suplidor debe revelar al Gobierno toda persona dueña, que tenga participación financiera o participación en el control del negocio.
18. El suplidor no deberá transferir o reasignar su número de suplidor (eje: el suplidor no puede vender o permitir que otra entidad use su número de suplidor de Medicare).
19. El suplidor debe establecer un protocolo para resolver quejas de los beneficiarios relacionadas a éstos estándares. Un registro de éstas quejas deberá ser mantenido en el local del suplidor.
20. El registro de las quejas debe incluir: nombre, dirección, número de teléfono y el número de Medicare (HICN) del beneficiario, un resumen de la queja y cualquier acción tomada para resolverla.
21. El suplidor debe acceder a proporcionarle a CMS cualquier información requerida por el estatuto y regulaciones de implementación de Medicare.
22. Todo suplidor debe ser acreditado por una organización de acreditación aprobada por CMS para obtener y retener sus privilegios para acturación. La acreditación debe indicar los productos y servicios específicos para los cuales el suplidor está acreditado, para que el suplidor reciba pago por esos productos (excepto ciertos productos farmacéuticos exentos).
23. Todo suplidor debe notificar a su organización de acreditación cuando abra un nuevo local de DMEPOS.
24. Cada local del suplidor, propio o subcontratado, debe cumplir con los estándares de calidad de DMEPOS y ser acreditado por separado para facturar a Medicare.
25. Todo suplidor debe revelar durante el periodo de inscripción, todos sus productos y servicios, incluyendo la adición de nuevos productos para los cuales está solicitando acreditación.
26. Debe cumplir con los requisitos de fianza de garantía especificados en 42 C.F.R. 424.57 (c). Fecha de implementación Mayo 4, 2009
27. El suplidor debe obtener oxígeno de un suplidor que tenga licencia del Estado para suplir oxígeno.
28. El suplidor debe mantener documentación, órdenes y referidos, de acuerdo con las provisiones que se encuentran en 42 C.F.R 424.516(f).
29. Los suplidores de DMEPOS tienen prohibido compartir su local con ciertos otros proveedores y suplidores de Medicare.
30. Los suplidores de DMEPOS deben permanecer abiertos al público por un mínimo de 30 horas por semana con ciertas excepciones.

Palmetto GBA
National Supplier Clearinghouse
P.O. Box 100142 x Columbia, South Carolina x 29202-3142 x (866) 238-9652
A CMS Contracted Intermediary and Carrier

DeanRosecrans

CDC **Centers for Disease Control and Prevention**
Your Online Source for Credible Health Information

What You Can Do to Prevent Falls

Many falls can be prevented. By making some changes, you can lower your chances of falling.:

Four things YOU can do to prevent falls

1. **Begin a regular exercise program**
2. **Have your health care provider review your medicines**
3. **Have your vision checked**
4. **Make your home safer**

1. Begin a regular exercise program
Exercise is one of the most important ways to lower your chances of falling. It makes you stronger and helps you feel better. Exercises that improve balance and coordination (like Tai Chi) are the most helpful. Lack of exercise leads to weakness and increases your chances of falling. Ask your doctor or health care provider about the best type of exercise program for you.

2. Have your health care provider review your medicines Have your doctor or pharmacist review all the medicines you take, even over–the–counter medicines. As you get older, the way medicines work in your body can change. Some medicines, or combinations of medicines, can make you sleepy or dizzy and can cause you to fall.

3. Have your vision checked
Have your eyes checked by an eye doctor at least once a year. You may be wearing the wrong glasses or have a condition like glaucoma or cataracts that limits your vision. Poor vision can increase your chances of falling.

4. Make your home safer
About half of all falls happen at home. To make your home safer:

- Remove things you can trip over (like papers, books, clothes, and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- Keep items you use often in cabinets you can reach easily without using a step stool.
- Have grab bars put in next to your toilet and in the tub or shower.
- Use non-slip mats in the bathtub and on shower floors.
- Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang light-weight curtains or shades to reduce glare.
- Have handrails and lights put in on all staircases.
- Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.

Page last reviewed: January 19, 2009
Page last updated: January 19, 2009
Content source: Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov

USA.gov

Please retain this patient copy for your records.

Revised 10/31/2013

DeanRosecrans

CUSTOMER INFORMATION CHECKLIST

Customer: _____

Equipment: _____

(Please Check Appropriate Items)

( ) Customer Information, Customer Complaints, Customer Rights and Responsibilities (See Separate Inserts)

( ) HIPAA Privacy Notice and Medicare Supplier Standards (See Separate Inserts)

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_____ Review printed safety precautions
_____ Explain customer's responsibility for routine maintenance, cleaning
_____ Give Company address, phone, and business hours
_____ Explain delivery options

Customer: _____ Date: _____

Relation: _____ Reason: _____

Customer Service Representative_____ Date: _____

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Revised 04/22/2014

DeanRosecrans

Please retain this patient copy for your records.

Access, Delivery and Service

Customer: _____

Equipment: _____

	Y	N	N/A
1. Equipment/Supplies was delivered in a timely manner.	____	____	____
2. Equipment/Supplies was ready for patient use upon delivery.	____	____	____
3. Received and understood instructions on proper application and use of equipment/supplies.	____	____	____
4. Feels confident to operate/use equipment/supplies.	____	____	____
5. Received information on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	____	____	____
6. Response to my questions, problems, concerns were addressed in a timely manner.	____	____	____
7. Satisfied with the equipment/supplies.	____	____	____
8. Satisfied with the service. Would recommend to others.	____	____	____

Comments:

_____
_____
_____
_____
_____
_____

Please retain this patient copy for your records.

DME Instruction Delivery/ Delivery Ticket

Name: _____ Initial Delivery Date: _____
Address:_____ Follow-up Date: _____

_____
City State Zip

Phone: _____
Alternate Contact: _____
Alternate Phone: _____

Equipment

Type of Product:	**Quantity:**
▪ ***90 Foam Filters:*** ***thin thick***	▪ ***Servox batteries:***
▪ ***24x3 Foam Strip :*** ***thin thick***	▪ ***Cloth covers:***
▪ ***6-9x24 Foam Sheets:*** ***thin thick***	▪ ***Shower collars:***
▪ ***9 Foam stoma covers:*** ***thin thick***	▪ ***Replacement tape: 3***

Romet Electrolarynx
Servox Electrolarynx

Est Prime Ins. payment	$
Est. Supplement Ins amt	$
Est. You will pay	$

Additional Instructions

The following has been given to the patient **(located in instructions, white packet enclosed with new unit, OR found on the customer information checklist sheet):**

- ☐ Rights & Responsibilities
- ☐ Purchase Information
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- ☐ Medicare Supplier Standards
- ☐ Warranty Information
- ☐ Privacy Notice
- ☐ Cleaning and Maintenance
- ☐ Equipment Instructions
- ☐ Complaint Process (how it is reviewed/resolved)

I have read, received and/or been instructed in detail on the items checked above.
(If patient unable to sign; authorized person complete)

Patient Signature:	Family/Guardian: Print name/relationship/reason patient is not able to sign:
Employee Signature:	Signature:

Please retain this patient copy for your records.

Revised 04/22/2014

DeanRosecrans
PO Box 553
Newtown Square, PA 19073
1-800- 237-3699

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold by **DeanRosecrans** carries a 1-year manufacturer's warranty. **DeanRosecrans** will repair or replace, free of charge, Medicare-covered equipment that is under warranty. However abuse, neglect, lost of components, as well as any modifications or alterations by the owner or an agent voids this warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

I have been instructed and understand the warranty coverage on the product I have received.

_____ _____

Beneficiary's Signature Date

Please retain this patient copy for your records.

USED WITH PERMISSION

Patients copy for records

Last Revision September 2013

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your protected health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your protected health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your protected health information
- Your privacy rights in your protected health information
- Our obligations concerning the use and disclosure of your protected health information.

The terms of this notice apply to all records containing your protected health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Compliance Officer, UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073 or toll free at (800) 985-3000.

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your protected health information:

1. Treatment. Our organization may use your protected health information to treat you. For example, we may perform a follow-up interview and we may use the results to help us modify your treatment plan. Many of the people who work for our organization may use of disclose your protected health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your protected health information to others who may assist in your care, such as your dentist, business associates, physician, therapists, spouse, children, or parents.

2. Payment. Our organization may use and disclose your protected health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your protected health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your protected health information to bill you directly for services and items.

3. Health Care Operations. Our organization may use and disclose your protected health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our organization may use and disclose your protected health information to contact you and remind you of visits/deliveries.

5. Health-Related Benefits and Services. Our organization may use and disclose your protected health information to inform you of health-related benefits or services that may be of interest to you.

6. Release of Information to Family/Friends. Our organization may release your protected health information to a friend or family member who is helping you pay for your health care of who assists in taking care of you.

7. Disclosures Required By Law. Our organization will use and disclose your protected health information when we are required to do so by federal, state, or local law.

8. Disclosures and uses not described in the Notice of Privacy Practices. Our organization will obtain patient authorization prior to any use or disclosure not described within the Notice of Privacy Practices.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your protected health information:

1. **Public Health Risks.** Our organization may disclose your protected health information to public health authorities who are authorized by law to collect information for the purpose of :
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury, or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
   - Notifying if there has been a breach of unsecured protected health information (PHI)
2. **Health Oversight Activities.** Our organization may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our organization may use and disclose your protected health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your protected health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release protected health information if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive, or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our organization may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military.** Our organization may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and =if required by the appropriate military command authorities.

7. **National Security.** Our organization may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates.** Our organization may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation.** Our organization may release your protected health information for workers' compensation claims and similar programs.

E. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information that we maintain about you:

Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Compliance Officer, **UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073. (800) 985-3000.**

Specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

1. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your protected health information for the treatment, payment, or health care operations in which you pay for the service in full, out of pocket. Additionally, you have the right to request that we limit our disclosure of your protected health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of disclosure of your protected health information, you must make your request in writing to Compliance Officer, **UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073. (800) 985-3000.** Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply. If the covered entity intends to engage in fundraising, a statement that it may contact the individual to raise funds for the covered entity and the individual has the right to opt out of receiving such communications.

2. **Inspection and Copies.** You have the right to inspect and obtain a copy of the protected health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing Compliance Officer UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073 in order to inspect and/or obtain a copy of your protected health information. Our organization may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

3. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to Compliance Officer, UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the protected health information kept by or for the organization; (c) not part of the protected health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

4. **Accounting of Disclosures.** All of our patients have the right to requests an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your protected health information. In order to obtain an accounting of disclosures, you must submit your request in writing to Compliance Officer, **UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073.**. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before September 1, 2006. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

5. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Compliance Officer, **UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073.**

6. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, Compliance Officer, **UltraVoice, Ltd., 90 South Newtown Street Road, Suite 14, Newtown Square, PA 19073.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

7. **Right to Provide an Authorization for Other Uses and Disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Authorization will be required for marketing purposes and the sale of protected health information that will result in remuneration to the covered entity along. Any authorization you provide to us regarding the use and disclosure of your protected health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your protected health information for the reasons described in the authorization. Please note that we are required to retain records of your care.

8. **Right to Know of Breach of Unsecured Protected Health Information**. You have the right to be notified in the event of a breach of unsecured PHI.

DeanRosecrans

PATIENT INFORMATION FORM

MEDICARE ☐ **MEDICARE ID NUMBER** _____

Date of Laryngectomy Surgery _____

PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) **PATIENT'S BIRTHDATE** MM | DD | YY **SEX** M F

PATIENT'S ADDRESS (NUMBER, STREET) **PATIENTS RELATIONSHIP TO INSURED** **Self** [ ] **Spouse** [ ] **Child** [ ] **Other** [ ]

CITY **STATE** **PATIENTS STATUS** **Single** [ ] **Married** [ ] **Other** [ ]

ZIP CODE **TELEPHONE NUMBER** (INCLUDE AREA CODE) ( ) **Employed** [ ] **Full Time Student** [ ] **Part Time Student** [ ]

INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

INSURED'S ADDRESS (NUMBER, STREET)

CITY **STATE**

ZIPCODE **TELEPHONE NUMBER** (INCLUDE AREA CODE) ( )

PLEASE NOTE:
***Leave no blanks**

*** Use Same or N/A (not applicable)**

*** PLEASE READ THE STATEMENTS BELOW**

*** And remember to sign at the bottom of form**

SECONDARY INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE)	**SECONDARY INSURANCE COMPANY**
SECONDARY INSURED'S ID NUMBER	**SECONDARY INSURANCE CLAIMS ADDRESS**
SECONDARY INSURED'S DATE OF BIRTH MM | DD | YY	**CITY** **STATE** **ZIP**
SECONDARY INSURED'S SEX M F	**SECONDARY INSURANCE TELEPHONE**

I authorize payment of medical benefits directly to the supplier for services furnished. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I give DeanRosecrans permission to appeal on my behalf any decision to deny coverage for the DeanRosecrans stoma supplies. I permit a copy of this authorization to be as valid as the original. By signing below, I also understand that I am responsible for notifying the provider of any changes in my status. I understand that my supplies WILL NOT be covered by Medicare if I am in the hospital, a Skilled Nursing Facility, or receive services from a Home Health Agency. I agree to accept financial responsibility for any such charges.

I, the undersigned, state the above facts are true and correct to the best of my knowledge, and I request payment of government benefits either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE _____ DATE _____

Patient Information form dated 6/25/2013

PLACE IN SELF ADDRESSED ENVELOPE AND RETURNED

DeanRosecrans

REFERRING PHYSICIAN'S PRESCRIPTION FORM
FOR
TRACHEOSTOMA COVERINGS AND/OR COMMUNICATION EQUIPMENT

My Patient
NAME
ADDRESS

had laryngectomy surgery for removal of a cancerous larynx.

Medicare Diagnosis Code **161.9**

Speech Aid (Artificial Larynx)
Replacement supplies (batteries, cords, tubes, etc.)
Repairs when needed (Speech Aid)
My Patient must use Tracheostoma Filters Daily, for tracheostoma protection and humidification.

Tracheostoma Filters_____ per day (quantity) Medicare Diagnosis Code **V44.0**

As of 10/1/2000 Medicare will not allow more than one filter per day, unless additional documentation is provided. If you are prescribing more than one filter per day for this patient, please provide additional information in the space below. This information will be used when submitting the Medicare Claim for this patient. Please be as detailed as necessary.

The term of need for the above supplies and/or equipment is permanent.

Signed _____ **Physicians NPI #**_____
Physician's Signature

PHYSICIAN'S NAME (PRINT or STAMP carefully) _____

Complete Address _____

City _____ **State** _____ **Zip code** _____

Phone Number (_____) _____ **Date** _____
area code

This form MUST be filled in, but another sheet of explanation may be added if needed for adequate documentation
This form is approved for use by Medicare Suppliers **PHOTOCOPY AS NEEDED**

PLACE IN SELF ADDRESSED ENVELOPE AND RETURNED

DeanRosecrans

Attention Patients

To be able to process your order with *Medicare or Private Insurance*, all forms (**Patient Information Form, Referring Physician's Form, & Customer Checklist Form)** are required to be filled out and returned with the stamped-self-addressed envelope provided for your convince.

When shipment of product, Forms: **Access, Delivery, & Service Form, Delivery Ticket Form, & Equipment Warranty Form** will be sent with shipment. The forms are required to be returned with the stamped-self-addressed envelope provided for your convince. This will ensure no interruption in future delivery of orders/shipment.

Thank you for your cooperation.

Sincerely,

Kathelleen P.
Office Administration Manager
DeanRosecrans