



# PAL-MED

## ASSIGNMENT OF BENEFITS AND SIGNATURE AUTHORIZATION FORM

Telephone Toll-Free 1-888-472-5633 Fax Toll Free 1-877-472-8555

P.O. Box 2538 West Columbia, SC 29171 803-791-9013

PATIENT NAME		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS	CITY	STATE	ZIP
INSULIN (IDDM)		NON INSULIN (NIDDM)	
<input type="checkbox"/>		<input type="checkbox"/>	
PATIENT MEDICARE OR SS NO.	PHONE NUMBER PLEASE INCLUDE AREA CODE ( )	EMPLOYED ? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced
EMERGENCY CONTACT AND TELEPHONE NUMBER		PHYSICIAN NPI	PHYSICIANS FAX #. ( )
PHYSICIANS NAME AND ADDRESS		PHYSICIAN UPIN	PHYSICIANS PHONE NUMBER ( )

### INSURANCE INFORMATION

#### #1 PRIMARY INSURANCE POLICY

#### #2 SECONDARY INSURANCE POLICY

NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
ADDRESS	ADDRESS
CITY	CITY
STATE	STATE
ZIP	ZIP
INSURANCE CO. PHONE NUMBER ( IF KNOWN)	INSURANCE CO. PHONE NUMBER ( IF KNOWN)
EFFECTIVE DATE OF POLICY	EFFECTIVE DATE OF POLICY
MEDICAID OR PRIVATE INSURANCE POLICY NO.	MEDICAID OR PRIVATE INSURANCE POLICY NO.

### SIGNATURE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby assign my Medicare/Medicaid and/or Private insurance benefits to Pal-Med, Inc., who is the supplier of my home diabetic supplies and request that payment under the medical insurance program be made to same. I have been explained of any deductible or co-pay not covered by my insurance and agree to pay.

I duly authorize Pal-Med to use and disclose any of my Protected Health Information (PHI) to Health Insurance Plans, Health Care Clearing Houses, and Health Care Providers as required for Treatment, Payment, and Operations (such as quality assurance and compliance protocol) in conjunction with the equipment and services the Company provides for my benefit. I understand that the Company will protect the privacy of my PHI as required by law (HIPAA) and that only the minimum necessary PHI will be used, disclosed, or requested to accomplish the intended purpose. I also understand that any disclosure not related Treatment, Payment, and Operations will require the Company to first obtain another Authorization from me that is separate and distinct for each such occasion.

I have been instructed on the use, and understand the warranty coverage, on the equipment that I have received.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

METER SERIAL # \_\_\_\_\_

**Medicare Supplier Standards**

109A

1. A supplier must be in compliance with all applicable Federal & State licensure & 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 Clearing House 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 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 DME, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty, honor all warranties under applicable law, & 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.
8. A supplier must permit CMS, or its agents to conduct onsite inspections to ascertain the supplier's compliance with standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must answer 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 or cell phone 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 & all customer's and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover the 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 calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contact.
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, phone # & health insurance claim number of the beneficiary, a summary of the complaint, & any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

**Rights, Responsibilities, Rental & Sales Agreement**

Company when used in this agreement, refers to PAL-MED, INC. Patient refers to the person receiving medical equipment & supplies. TITLE to the rental equipment & all parts shall remain with the Company, unless equipment is purchased & paid for in full. Patient must promptly notify Company of rental equipment malfunctions or defects & allow Company representatives to enter their premises to perform REPAIR & SERVICE. Company shall not insure or be responsible to patient or caregiver for any PERSONAL INJURY OR PROPERTY DAMAGE related to any product, including that caused by improper use or function thereof, the act or omission of any third party, or by any criminal act or activity, fire or act of God. Company may impose a monthly service charge of 1 1/2% of the unpaid balance. Sales RETURNS may be accepted in unopened packages &/or salable condition within three (3) days from date of original invoice with proof of purchase. Due to health department regulations, no merchandise may be accepted for return if worn next to the skin, food product, used for sanitary or hygienic purposes or if it is disposable (electrodes, wipes, creams, batteries, etc.). Special order items will require a deposit & are non-returnable. Patient is responsible for monitoring supply levels. Should a life-threatening MEDICAL EMERGENCY arise the patient or caregiver contact their local emergency services number for assistance. Patient retains the right to refuse Company services & assumes responsibility for any consequence relating to REFUSAL of any service ordered delivered to the patient by a healthcare professional. Patient may participate in all decisions regarding service, including admission, plan of service, of anticipated outcomes of service and of any barriers in outcome achievement, discharge, transfer & referral and will receive experimental treatment only with a voluntary informed consent. Patient personal healthcare information listed on the reverse side will be kept CONFIDENTIAL by Company and only used for healthcare operations, services & payment purposes. In the interest of health & safety, Company retains the RIGHT TO REFUSE DELIVERY of service at any time, however, does not discriminate. Patient has a right to respect, dignity, privacy, choice, informed consent, special communication needs, participation in the care planning process, adequate care & services, appropriate assessment and management of pain, description & charges of those services available and payment for them. Patient agrees to NOTIFY Company of any MEDICAL STATUS change such as doctor's prescription, advance directives being in place or changed, acquiring an infection requiring hospitalization or MD visit, change of residence or insurance coverage. Company is privately-owned and any financial benefits of referrals made by the Company will be disclosed to the patient. Patient will be communicated in a way they can understand. Those wishing to express their concerns or comments or review, amend, review disclosure, restrict or revoke consent on their records, should contact the Company during regular business hours, your COMMENTS will be reviewed and you will be contacted within three business days. We will attempt to resolve your issue as soon as possible. We are an approved Medicare (800 633-4227) provider. Patient & Company agree to go to arbitration if a disagreement arises between the parties. **Mission Statement** We are dedicated to exceeding our customer's expectations in providing the greatest quality and value in healthcare related products, supplies and services.

**Patient Health Information-Privacy Notice**

Please note that we maintain paper & electronic files that may contain private information about you that may include, but are not limited to your name, address, phone number, contact person, height & weight, diagnosis, prognosis, physician(s), prescriptions, plans of service & treatment, vital signs & other clinical impressions, insurance coverage(s), equipment rented & purchased from us, credit card number(s), dates of service, etc. We release, transfer & disclose the above information to third parties to facilitate appropriate provision & review of services & billing for our clients of record. These files are legal documents & are also used for education, evaluating the performance of our organization, marketing & planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to, security precautions being in place in our buildings, vehicles, billing software, transactions with government entities, vendors, consultants, surveyors, your family or appointed representative & other appropriate parties, transmission of data to third-parties, telephonic & wireless communications, maintenance, retention & destruction of data, etc. You have the right to amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file & have released to others upon request. If you have questions concerning any of the above, please contact our Privacy Officer at the number shown on this form. Effective 04/11/03.

*Listed equipment set-up &/or maintained per manufacturer guidelines; functional limitations, environmental/architectural barriers/electrical & safety checks per Company policy; equipment use, warranty, availability of service & rights & responsibilities explained to patient/caregiver:*

PAL-MED, INC. **Staff X** \_\_\_\_\_ **Date** \_\_\_\_\_

**RECEIVED BY, ACKNOWLEDGMENT OF INSTRUCTIONS & RETURN DEMO:** I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use & care of the equipment or supplies received today & described on this document & will follow them. I understand Company business hours. If this was a pick-up or return of equipment, I acknowledge that I have returned the item(s) listed to your staff. I acknowledge receipt & understanding of the Company Patient Health Information Privacy Notice, Rights & Responsibilities, Medicare Supplier Standards & that all information on both sides of this document is correct:

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE:** I request that payment of authorized Medicare & other benefits be made on my behalf to **PAL-MED, INC.** for products & services that they have provided me. I understand that a **PAL-MED, INC.** representative will be contacting me regarding my financial responsibilities related to this agreement. I further authorize a copy of this agreement to be used in place of the original to release to The Centers for Medicare & Medicaid Services and its agents or other payers, any information needed to determine these benefits or compliance with current healthcare standards. **PAL-MED, INC.** bills third-party payers as a courtesy; I understand that I am fully responsible for all deductibles, coinsurance & disallowable (unpaid items). I acknowledge that Medicare or other insurance has not purchased or rented same or similar items, as listed above, in the past:

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

If signed by caregiver or other, please list relationship and diagnosis related reason for not signing (Example: Husband, Sister, R.N., etc. & "patient unable to sign due to Parkinson's, Amputation, etc.")