

# Suggested Intake Form

Order taken by:		Date:	
Referral Person Calling in Order:		Telephone:	
<b>BENEFICIARY INFORMATION</b>			
Name:		Date of Birth:	
Street Address:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City, State, Zip:		Weight:	Height:
Telephone:		Medicare Number:	
<b>Name of Legally Responsible Representative:</b>			
Relationship to beneficiary:			
Street Address:			
City, State, Zip:		Telephone:	
<b>ORDERING PHYSICIAN INFORMATION</b>			
Name:		NPI #	
Street Address:			
City, State, Zip:		Telephone:	
Specialty:			
<b>QUESTIONS FOR THE BENEFICIARY</b>			
Has the beneficiary ever received the same or similar supplies/equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list equipment/supplies:			
Who was it purchased or rented from?			
Date purchased or if rented, how many months?	Date of past setup:	Date equipment was returned:	
Was item returned to original supplier?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Why was the item returned?			
Is the item being replaced?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a new medical necessity?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe condition for previous need:			
Describe new/changed condition:			
Is the beneficiary enrolled in a Medicare HMO/managed care program?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>QUESTIONS FOR THE SUPPLIER</b>			
<b>If providing repairs on equipment obtain the following information for the item being repaired:</b>			
Manufacturer:	Model Name or Number:	Serial Number:	Purchase Date:
Reason or nature of repairs:			
Do you have medical necessity to file for repairs?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does beneficiary meet criteria for item being repaired? <input type="checkbox"/> Yes <input type="checkbox"/> No		Where will the item be used?	
Did I photocopy the Medicare card and/or other insurance cards?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do I have a dispensing order and/or a detailed written order?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will I need a Certificate of Medical Necessity (CMN)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do I have supporting documentation on file to meet medical necessity?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Should I obtain an Advance Beneficiary Notice (ABN)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the primary diagnosis?	List any other diagnoses if applicable:		
Is Medicare the beneficiary's <input type="checkbox"/> primary or <input type="checkbox"/> secondary insurer?			
Is the beneficiary or beneficiary's spouse employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the current condition related to employment, auto or other accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the beneficiary nearing Medicare eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give eligibility date:	
Do I need to obtain a one-time authorization form?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the beneficiary sign and date this intake form?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Beneficiary Signature:		Date Signed:	
<p>This is just a <b>suggested</b> intake form and suppliers can model one to fit their particular type of business. For example, if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or, if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advance Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the DME MAC Jurisdiction C Supplier Manual, Chapter 3, for information about Same/Similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.</p>			

