

GU0502-12/08

Professional Medical Intake & Medical Audit Form

Name of Person Performing Intake _____

Auditing Checklist

This section to be completed prior to the file being sent in for billing & completed by an auditor.

Intake Sheet Completed

- Client Info complete including height & weight
- Physician Info & NPI
- Emergency Contact completed
- Patient Diagnosis Info correct & relevant to equipment delivered
- SNF / Hospital D/C Date complete and equipment delivery date on/after D/C date (applicable notes included)
- Same or similar checked via IVR 866-238-9650

Delivery Ticket Completed

- Date of Service
- Name & Address
- Equipment Type
- Delivery Ticket Signed
- Delivery Ticket Dated
- Co-pay % / authorization
- Equipment Se #
 - if N/A requires lot #
- Equipment Lot #
 - if N/A requires se#
- Equipment Manufacturer
- Equipment Model Name/Item #
- Warranty field
- Blanks Initialed by client

Medical Documentation Complete and attached

- Signed Physician's Order Attached
- CMN or DIF or Valid Oxygen/PAP Order
 - N/A
- Home Assessment
- Plan of Service or Patient Assessment (PAP / shoes / oxygen / wheelchairs / clinical RT)
- Progress Notes, lab results, or H&P on file for items requiring KX modifier N/A no KX
- Patient meets criteria and documentation is included per payer policy (when required by equipment LCD)
 - N/A no KX modifier

Notes:

Ok to send for billing
Employee Initials _____
Date _____

Client Information

Client Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:	
Address:		Ht	Wt	SS#
City:	State: Zip:	email address:		DOB:

Responsible Party if Other Than Patient (Bill to Address)

Name:		Relation:		Phone:	
Address:		City:		State:	Zip:

Next Kin / Emergency / Alternate Contact Person (Must Not Be Living With The Patient & be a different phone number)

Name:	Phone:	Relation:	Caregiver Name
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Physician Information

Name:	NPI #:	Phone:	Fax#:
Address:		City:	State: Zip:

Recent Hospitalization Information

Name:	Discharge Date:	Rm#:
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Diagnosis Information

1)	ICD-9	Test Location, testing parameters, results, order specifications:
2)		
3)		Relevant Claim Modifiers: (describe all)
4)		

Oxygen Information

Medicare Information

Medicare #:	Part B Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	IVR Results/date/initials:
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Primary Private Insurance Information

Insurance Co:		Phone #:		Employer	
Claims Address:		City:		State:	Zip:
Policy Holder:	Policy #:	Group #:		Precertification #:	
Deductible:	Percentage Covered:	Policy Max:	Contact:		

Secondary or Supplemental Insurance Information

Insurance Co:		Phone #:			
Claims Address:		City:		State:	Zip:
Policy Holder:	Policy #:	Group #:		Precertification #:	

Worker's Compensation Information (Fill in Insurance Information Above in the Private Insurance Area)

Employer:	Phone #:	Address:		City:	State:	Zip:
Adjuster:	Phone #:	Date of Injury:	Authorization #:	Claim #:		

Special Payer Rules

Please Note any special payer rules or policies

Referral Information

Referral Source / Contact Person:	Phone #:	Call In Date
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Equipment Requested _____