Intake Form

Referral Source: Referral Phone: Intake Date: Sales Rep: Wayne VanBrocklin ATP

Therapist: Therapist Email:

Client Information

Client Name (First, Middle, Last):

Street 1:

Street 2:

City: State: ZIP:

Client Phone: Emer. Cont.:

Emer. Cont. Address:

Emer. Cont. Phone (H): Cellular Phone:

Cellular Carrier:

DOB:

Sex:

Prognosis:

Client Email:

Length of Need (months):

Equip. New, Rent, Other:

Diagnosis Code 1: Diagnosis Description 1:

Diagnosis Code 2: Diagnosis Description 2:

Diagnosis Code 3: Diagnosis Description 3:

Diagnosis Code 4: Diagnosis Description 4:

Client Height: Ft In Overall Weight: lbs

Insurance Information

Primary Carrier:

Insured Name:

Insured ID#:

Group #:

Phone #:

Contact:

Secondary Carrier:

Insured Name:

Insured ID#:

Group #:

Phone #:

Contact:

Tertiary Carrier:

Insured Name:

Insured ID#:

Group #:

Phone #:

Contact:

☐ PECOS Certified

Physician Information

Name:

Street 1:

Street 2:

City: State: ZIP:

Phone #:

Fax #:

UPIN #:

License #:

NPI #:

Rehabilitation Equipment Professionals, Inc.
PATIENT SERVICE AGREEMENT

Patient Name: ______________________________ ID ______________________

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize Rehabilitation Equipment Professionals, Inc. under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly Rehabilitation Equipment Professionals, Inc., Inc for any home medical equipment, supplies and services furnished to me in conjunction with my home care. I authorize Rehabilitation Equipment Professionals, Inc. to seek such benefits and payments on my behalf. It is understood that, as a courtesy. Rehabilitation Equipment Professionals, Inc. will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to Rehabilitation Equipment Professionals, Inc. I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to Rehabilitation Equipment Professionals, Inc. within 30 days of the event. I have been informed by Rehabilitation Equipment Professionals, Inc. of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize Rehabilitation Equipment Professionals, Inc., the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Rehabilitation Equipment Professionals, Inc., any payer source, physician, or any other medical personnel or agency involved with service. I also authorize Rehabilitation Equipment Professionals, Inc. to review medical history and payer information for the purpose of providing home health care.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, Rehabilitation Equipment Professionals, Inc. does not receive payment from my payer source, I hereby agree to pay Rehabilitation Equipment Professionals, Inc. for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

_______ (Initials) I acknowledge that I have been advised of my financial obligations to Rehabilitation Equipment Professionals, Inc..

Returned Goods: I understand that, due to Federal and State Pharmacy Regulations ancillary items prescribed for home health care cannot be re-dispensed. Therefore, ancillary items cannot be returned for credit. Home Medical Equipment that is rented will be returned after the physician has discontinued service. Sale items cannot be returned. Rehabilitation Equipment Professionals, Inc. must be notified within 24 hours of the set-up if any equipment is defective. In the case of defective equipment, an exchange will be made for the defective item.

Patient Handouts: I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, Supplier Standards, Home Safety Information, HIPAA Privacy Standards, Warranty, Emergency Planning, and Marketing Material / Scope of Service. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information. I understand my right to formulate and to issue Advance Directives to be followed should I become incapacitated. I will furnish Rehabilitation Equipment Professionals, Inc. with a copy of such document.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 703-370-2100 and speak to the Customer Services Supervisor. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

Home Health Hotline: You may also make inquiries or complaints about this company by calling your local Social Services Department and/or the Accreditation Commission for Health Care (ACHC) at 919-785-1214.

Patient: ______________________________ Date: ______________________

Witness: ______________________________ Date: ______________________

Form Revised: 08/02/2011, 04/19/2017

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___   3. ___ . ___

2. ___ . ___   4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.