DELIVERY/PICKUP/SERVICE TICKET

☐ Delivery ☐ Pickup ☐ Service Date: _____

Beneficiary name:				Acct#:
Address:	City:		State:	Zip:
Phone #:	DOB:	Sex:	Height:	Weight:
Social Security #:	Medicare #:		Medicaid #:	
Doctor:	Phone #:	Fax #:		UPIN:
Address:				

Quantity	**HCPCS Code**	**Description**	**Item Code #**	**Model / Serial#**

Comments / Instructions / Notes

_____

_____

_____

_____

I ACKNOWLEDGE RECEIPT OF THE ABOVE LISTED PRODUCTS.

_____ _____ _____ _____

Beneficiary (or Parent/Guardian/Agent) Signature **Date** **Delivery Staff** **Date**

_____

Parent/Guardian/Agent's Relationship to Beneficiary

_____

Parent/Guardian/Agent's Address and Telephone

Telephone: _____

Reason Why Beneficiary Could Not Sign

☐ Beneficiary physically unable
☐ Beneficiary cognitively impaired
☐ Beneficiary clinically unable to be disturbed
☐ Beneficiary is a minor
☐ Beneficiary pending discharge from a facility _____

CUSTOMER INFORMATION CHECKLIST

Customer Information _____ **HIC# /ID#** _____

(Please Check Appropriate Items)

☐ **Customer Information, Customer Complaints, Customer Rights and Responsibilities** (See Separate Insert)

☐ **HIPAA Privacy Notice and Medicare Supplier Standards** (See Insert)

☐ **Acceptance of Services**

I understand that by signing this agreement, I authorize provision of products and/or services to me by Diabest, Inc. I also understand that the products and services provided are prescribed by my physician and that is necessary that I remain under the supervision of my attending physician during the course of my care.

☐ **Release of Information**

I hereby authorize release to Diabest, Inc 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 Diabest, Inc to furnish to my insurance carrier(s), and medical history, services rendered, or treatment needed. I further authorize DIABEST, Inc, the Accreditation Organizations, and other licensing bodies to periodically examine my records for the purpose of checking compliance to regulations and quality assurance requirements.

☐ **Assignment of Benefits**

I authorize direct payment of insurance benefits by my insurance company to Diabest, Inc. 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 Diabest, In**c** for payment of my bill.

☐ **Financial Responsibility**

I understand and I acknowledge that I am responsible to Diabest In**c** 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 the rental and/or 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 Diabest, In**c** for all charges.

☐ **Equipment Warranty Information**

I understand and I acknowledge that every durable medical equipment product sold or rented by DIABEST, INC. carries a 1-year manufacturer's warranty. I understand and I acknowledge that DIABEST, INC. will notify all Insurance beneficiaries of the warranty coverage, and DIABEST, INC. will honor all warranties under applicable law. I understand and I acknowledge that DIABEST, INC. will repair or replace, free of charge, Insurance-covered equipment that is under 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. (See Separate Insert)

☐ **Return/Exchange/Repair Policy**

I understand and I acknowledge that DIABEST, INC. Will accept returns for durable medical equipment items -for repair or exchange- from beneficiaries 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)

☐ **Rental and Inexpensive or Routinely Purchased Items Notification**

I understand and I acknowledge that DIABEST, INC. Explained the following criteria:

FOR CAPPED RENTAL ITEMS:

Insurance will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Insurance beneficiary. After ownership of the equipment is transferred to the Insurance beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair. Examples of this type of equipment include:

Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars…

FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. Examples of this type of equipment include: Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymph edema pumps), bed side rails, and traction equipment…

I have selected the following option ☐ **PURCHASE** ☐ **RENTAL**

☐ **Equipment Set-Up and Instruction**

- ☐ Assemble and install equipment
- ☐ Perform safety and operation checks
- ☐ Environmental and safety checks
- ☐ Assess risk of patient harm resulting from falls
- ☐ Demonstrate equipment and give verbal instruction to patient and caregiver
- ☐ Instruct alternate caregiver if appropriate
- ☐ Review printed education material including printed safety precautions
- ☐ Explain physician's Rx for equipment use
- ☐ Explain need to contact Diabest, Inc if any change in patient status
- ☐ Give Diabest, Inc address, phone, and business hours
- ☐ Explain delivery policy
- ☐ Explain on-call policy
- ☐ Explain customer's responsibility for routine maintenance, cleaning, infection control
- ☐ Explain procedure for non-operating equipment
- ☐ Explain Functionality, Operation, Maintenance and security tips in the regular use for the products
- ☐ Explain "follow-up" normally performed by Diabest, Inc

I ACKNOWLEDGE, UNDERSTAND AND RECEIVE THE ENTIRE CONTENTS OF THIS DOCUMENT.

_____ _____

Beneficiary (or Parent/Guardian/Agent) Signature **Date**