At AlphaMed we try to provide each client with the product and equipment that he or she needs. However, some insurance policies will not cover all equipment that may be ordered. Please print and read this packet for a general list of covered and non-covered items. Each insurance policy is different, and it is impossible to know until we submit your order to the insurance provider what will be covered. Thank you for giving us the opportunity to serve you and if we can be of any other service please contact us using the contact information provided in this packet.
AugComm Device Checklist

1. Signed physician Rx for devices or accessories needed

2. Letter of Medical Necessity or Speech Evaluation

3. Client Demographics that include: Name, DOB, Address (No PO boxes for shipping reasons), Insurance Information (Copy of cards if possible), Working phone numbers, physician name.

4. Quote for equipment from AMDI.

If you do not have a signed Rx please print off the one included in this packet and have the physician sign.
Augmentative Communication Services Department

Ph (731) 660-0060  Fax (731) 660-0622
Showroom: 935 Old Humboldt Rd, Ste A, Jackson, TN 38305
Send Mail To: PO Box 10728, Jackson, TN 38308

Augmentative Communication Device

<table>
<thead>
<tr>
<th>Patient Info/Insurance Data</th>
<th>Physician Contact Info/NPI</th>
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Ph: (____)_________ DOB:__________

HICN: ______________________

Office#: (____)_________ Fax: (____)_________

NPI: ______________________

Narrative Description of Equipment and Cost

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>QTY</th>
<th>HCPCS</th>
<th>Description</th>
<th>CHG (Office Use)</th>
<th>Allow (Office Use)</th>
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1. Length of need_____ 99=lifetime
2. Diagnosis/Conditions: ____________________ ____________________

Physician Signature:___________________ Date:________
Physician Printed Name__________________ NPI________________
### Sample RX

**Augmentative Communication Device**

<table>
<thead>
<tr>
<th>Patient Info/Insurance Data</th>
<th>Physician Contact Info/NPI</th>
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</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>John Smith M.D.</td>
</tr>
<tr>
<td>999 Old Oak Street</td>
<td>184 Maple Cove</td>
</tr>
<tr>
<td>Jackson Tn 38305</td>
<td>Jackson Tn. 38305</td>
</tr>
<tr>
<td>Ph: (731) 660-0060</td>
<td>Office: (731) 660-0060</td>
</tr>
<tr>
<td>DOB: 4/1/66</td>
<td>Fax: (731) 660-0622</td>
</tr>
<tr>
<td>HICN: 410879809A</td>
<td>NPI: 123456789</td>
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**Narrative Description of Equipment and Cost**

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<th>CHG</th>
<th>Allow</th>
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</thead>
<tbody>
<tr>
<td>AMDI</td>
<td>1</td>
<td>E2500</td>
<td>Tech Talk 8</td>
<td>460.00</td>
<td>410.20</td>
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1. **Length of need**: 99=lifetime

2. **Diagnosis/Conditions**: Mental Retardation  Developmental Delay

**Physician Signature**:__________________________ Date:____________

**Physician Printed Name**:________________________NPI:________________
Items Usually Not Covered by Insurance

- Mounting systems (for table, beds, chair)
- Carry Cases (Covers)
- Extended Batteries
- Tech Caps
- Manuals
- Overlays

In most cases only the devices themselves are covered items. We will always submit all products to be covered and will always contact the person placing the order to discuss any non-covered items.
**SALES & RENTAL DELIVERY INVOICE**

**CUSTOMER INFORMATION**

Name: ____________________________
Address: __________________________
City: ______________St:_____ZIP_______
Phone: ____________________________
SSN: ______________________________
DOB: ___________Diagnosis: __________
Physician: ___________________________

**BILLING INFORMATION**

Primary Insurance: ________________
Secondary Insurance *: ________________
( lights if no 2ndary, complete Co-Ins Form supplied in this packet)
Recent Insurance change? ______
If Medicare pt, is pt enrolled in an HMO? ______
If yes, name of HMO: __________________
If yes, auth#: ___________ exp:_________

**QTY** | **DESCR** | **ITEM #/ SERIAL #** | **HCPCS** | **CHRG or PYMNTS** | **DETAILS**
--- | --- | --- | --- | --- | ---
| | | | | | Rental Purchase

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**Payments Reflect:** ( ) Retail Sale ( ) Private Purchase ( ) 20% Member Portion

**Comments:** __________________________________________________________

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**Plan of Service Acknowledgement**

*Proof of Delivery,* I acknowledge receipt of the above equipment in clean and good working order. I have received Training Materials for safe and proper use of the equipment, including cleaning and maintenance. I have received a copy of AlphaMed’s HIPAA Standards, CMS Supplier Standards, Patient Rights and Responsibilities, and AlphaMed’s Scope of Services.

**Assignment of Benefits,** I authorize release of Medical Information as necessary to justify the need for medical equipment and authorize payments to be paid directly to AlphaMed, Inc. I agree, whether I sign below as agent or patient, to accept all financial responsibility for the medical equipment furnished to me or the patient by AlphaMed, Inc. A copy of this agreement may be used in place of the original.

**Sales and Rentals,** All sales are Final. No refund on purchased or early return of rental equipment.

Patient or Authorized Rep* Signature: ____________________________ Date: __________

* If other than patient is signing, state reason & relationship to Patient: ____________________________

Delivered by: __________________________________________ Date: __________

Please fax to: 731-668-2250