AlphaMed Inc

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.

ACHC ACCREDITED

ATP RESNA CERTIFIED ASSISTIVE TECHNOLOGY PROFESSIONAL

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.

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

Patient Info/Insurance Data	Physician Contact Info/NPI
_____	_____
_____	_____
_____	_____
Ph: (_____)_____DOB:_____	Office#: (___)_____Fax: (___)_____
HICN: _____	NPI:_____

Narrative Description of Equipment and Cost

Manufacturer	QTY	HCPCS	Description	CHG (Office Use)	Allow (Office Use)

1. Length of need_____ 99=lifetime

2. Diagnosis/Conditions: _____ _____

Physician Signature:_____ Date:_____

Physician Printed Name_____ NPI_____

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

Sample RX

Augmentative Communication Device

Patient Info/Insurance Data	Physician Contact Info/NPI
John Smith 999 Old Oak Street Jackson Tn 38305 Ph: (731) 660-0060 DOB:4/1/66 HICN: 410879809A	John Smith M.D. 184 Maple Cove Jackson Tn. 38305 Office: (731) 660-0060 Fax: (731) 660-0622 NPI:123456789

Narrative Description of Equipment and Cost

Manufacturer	QTY	HCPCS	Description	CHG	Allow
AMDI	1	E2500	Tech Talk 8	460.00	410.20

1. Length of need___99__ 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.

AlphaMed Inc
Begin Here

SALES & RENTAL DELIVERY INVOICE

Date & Time of Delivery: _____ Date & Time Notified of Request: _____

CUSTOMER INFORMATION

Name: _____

Address: _____

City: _____St:_____ZIP_____

Phone: _____

SSN: _____

DOB: _____Diagnosis: _____

Physician:_____

BILLING INFORMATION

Primary Insurance: _____

Secondary Insurance *: _____
*(*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: _____

Is pt in PPO? _____

If yes, auth#: _____ exp:_____

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

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

Comments: _____

Plan of Service Acknowledgement
Terms and Conditions

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