



NEW PATIENT SET UP CHECK LIST

FAX # (847) 816-8606

Just five forms are needed to set up a patient with Koffel Medical Supply:

1. INSURANCE INFORMATION

If you fax us the insurance information along with your intake/demographics sheet, **we will fill out all paperwork and overnight it back to you or fax it back to you within an hour for the patient's signature.**

2. METHOD SELECTION FORM

Please provide a copy of HCFA 382. *(Be sure Method II is selected)*

3. PATIENT AGREEMENT/ASSIGNMENT OF BENEFITS

Please have the **patient sign** and date this form.

*This form is provided in your Koffel Medical Start Up Packet.

4. MEDICARE SUPPORT SERVICE AGREEMENT

Please complete this form and have **representative from facility sign and date** for each new patient. This form is located on the bottom of the Method II Patient Set-up Checklist.

5. PRESCRIPTION

Please provide us with the original of the manufacturer's prescription for dialysis supplies. We will send a copy to the manufacturer. (Please make sure the prescription is signed and dated by the patient's nephrologist)

ESRD BENEFICIARY SELECTION (Home Patients Only)

PLEASE READ INSTRUCTIONS ON REVERSE BEFORE COMPLETING THIS FORM

1. **NAME** (Last, First, Middle Initial)

2. **HEALTH INSURANCE CLAIM NUMBER** (Medicare Claim Number)

3. **DATE OF BIRTH** (month/day/year)

4. **SEX**

Male

Female

5. **PROVIDER NUMBER OF FACILITY PROVIDING HOME DIALYSIS TRAINING**

5A. **NAME AND ADDRESS OF FACILITY PROVIDING HOME DIALYSIS TRAINING**

6. **PROVIDER NUMBER OF FACILITY PROVIDING HOME DIALYSIS SUPPORT SERVICES**

6A. **NAME AND ADDRESS OF DIALYSIS FACILITY PROVIDING SUPPORT SERVICES**

7. **BENEFICIARY SELECTION, CHANGE OR CANCELLATION**

Initial Selection

Cancellation

Routine Method Selection Change

Method Exception (Refer to PRM, Part I-Chap. 27, §2740.2.D.) Intermediary approval required.

Reason for Exception _____

8. **TYPE OF DIALYSIS** (Check One)

Hemodialysis

CAPD

CCPD

9. **DATE HOME DIALYSIS TRAINING IS COMPLETED**

10. **CHECK METHOD I OR II**

METHOD I – The ESRD facility indicated in #6 will supply all the equipment, supplies, and support services necessary for me to dialyze at home.

METHOD II – I will deal directly with one supplier for my home dialysis supplies and equipment, and my support services will be provided by the dialysis facility indicated above.

11. **NAME AND ADDRESS OF THE DURABLE MEDICAL EQUIPMENT SUPPLIER THAT WILL PROVIDE THE SUPPLIES AND EQUIPMENT** (Only appropriate if beneficiary chooses Method II)

12. If I have chosen Method II, by signing this form, I certify that I have only one Method II supplier. Further, I understand that if my supplier does not take assignment, Medicare will not pay anything toward my supplier's bill.

13. **CHECK LOCATION WHERE HOME DIALYSIS IS PROVIDED**

Private Residence

Skilled Nursing Facility

Nursing Home

14. **BENEFICIARY SIGNATURE**

15. **DATE BENEFICIARY SIGNS FORM** (month/day/year)

16. **DATE METHOD EXCEPTION TO BE EFFECTIVE** (month/day/year)

(INITIAL SELECTION CHANGES, ROUTINE SELECTION CHANGES, AND CANCELLATIONS BECOME EFFECTIVE ON JANUARY 1 OF THE YEAR FOLLOWING THE YEAR IN WHICH THIS FORM IS SIGNED)

17. The dialysis facility providing the home dialysis training is responsible for supplying this form to Medicare beneficiaries who select home dialysis and for sending the white copy of the completed form to the local Part A Intermediary (both Method I and Method II selections). Blank forms are available from the Intermediary. The white copy of this form must be sent to:

THE LOCAL INTERMEDIARY
ATTN: MEDICARE PROGRAM ADMINISTRATOR

A copy of the form must also be sent to the dialysis facility providing support services and to the supplier if the beneficiary chooses Method II.

INSTRUCTIONS FOR COMPLETING THE ESRD BENEFICIARY SELECTION FORM

Centers for Medicare & Medicaid Services regulations provide two (2) ways that a Medicare beneficiary dialyzing at home can choose to have the Medicare program pay for his/her dialysis care (exclusive of physician services). The purpose of the Beneficiary Selection form is for you, the beneficiary, to select the method that best suits your requirements. It is important you choose one of these two methods, complete and sign the form and return it to the dialysis facility that supervises your care as soon as possible. You must complete all sections of this form.

This form is to be filled out only by Medicare beneficiaries dialyzing at home and not by Medicare beneficiaries who are currently dialyzing in a facility.

Your selection of either Method I or Method II in no way inhibits your return to incenter treatment or selection for any other treatment options should that be necessary.

METHOD I – The first method is for your dialysis facility to assume the responsibility for your care. Under this method, the facility is required to provide to you any and all dialysis equipment, supplies and home support services that you need to dialyze at home. It also is required to order, store, deliver, and pay the manufacturers and suppliers for these items. Under this arrangement you are responsible to your dialysis facility for the Medicare Part B deductible and 20% coinsurance.

METHOD II – While your facility is responsible for assuring that you receive all items and services that you require for home dialysis, the second method allows you to deal directly with a single supplier for securing the necessary dialysis equipment and supplies. Then your supplier bills the Medicare program for payment. Under this arrangement, you are responsible to the supplier for the Medicare Part B deductible and 20% coinsurance.

METHOD CHANGES – Once you have made your initial selection, your reimbursement must be handled in that manner until December 31 of the year in which you signed the ESRD Beneficiary Selection form. If you wish to continue your initial selection beyond December 31, you do NOT complete another ESRD Beneficiary Selection form. You will automatically continue to have your reimbursement handled in the manner you selected. If you do not wish to continue with your initial selection beyond December 31, you MUST complete another ESRD Beneficiary Selection form. This subsequent form must be signed, dated and postmarked PRIOR to January 1 of the year you wish your selection change to be effective. This is the only way changes are made, and this is the only reason you should ever complete more than one ESRD Beneficiary Selection form.

PRIVACY ACT STATEMENT

As required by 5 U.S.C. 552a (the Privacy Act of 1974), you are advised that the Centers for Medicare & Medicaid Services is authorized to collect the data on this form by Section 1881(b)(1) of the Social Security Act and 42 CFR 405.544. The purpose for collecting this information is stated above. Your response to the questions on this form is not required by law. However, if you do not provide this information, requests for end-stage renal dialysis reimbursement may be denied or delayed until it is provided. You should be aware that the information you provide may be verified by a computer match (P.L. 100-503).

Individually identifiable patient information will not be disclosed except as provided for by the Privacy Act.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0372. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



ASSIGNMENT OF BENEFITS

Patient Name: _____

GENERAL AGREEMENT

I have chosen Koffel Medical Supply, Inc. to be my supplier of home dialysis supplies and equipment prescribed by my attending physician. I understand my physician is solely responsible for ordering all necessary dialysis supplies and equipment for my home dialysis treatments and, for supervising and controlling my medical condition.

AGREEMENT TO PAY

In consideration of Koffel Medical Supply, Inc. undertaking to supply the dialysis supplies, equipment and/or services ordered by or on behalf of me, I agree to assume payment responsibility of any and all such supplies, equipment, and/or services. This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois, without giving effect to any choice of law or conflict of law provision or rule (whether of the State of Illinois or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than that of the State of Illinois.

ASSIGNMENT OF BENEFITS

I hereby authorize Koffel Medical Supply, Inc. to request on my behalf and collect directly all public and private insurance benefits due for the purchase of dialysis supplies and equipment supplied by Koffel Medical Supply, Inc. In the event any payments due to Koffel Medical Supply, Inc. are received by me, I hereby agree to endorse such payments over to and forward them directly to Koffel Medical Supply, Inc. In addition, I hereby authorize Koffel Medical Supply, Inc. to submit appeals, if necessary, to my insurance carrier(s) on my behalf.

RELEASE OF INFORMATION

I authorize any holder of medical information about me to release to your company, the insurer, or HCFA and its agents any information needed for this or related claims. Further, I authorize the release of all information pertaining to insurance benefits and status of claims submitted to the same referenced parties.

I certify that I have read the above information. I also certify that the undersigned is either the patient, or, is an authorized agent of the patient to execute and accept the above items.

Signature of Patient/Authorized Agent

Date

Relationship to Patient If Other Than Patient

Notice of Koffel Medical Supply, Inc. Privacy Policy

Koffel Medical Supply, Inc. will comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996, (Code 45 CFR 164-the Federal Privacy Regulations). The healthcare information you and/or your clinical care staff provide will only be used as necessary to process your home dialysis supply/equipment orders and applicable insurance claims. Safeguards have been implemented to maintain your medical record information confidential. Any questions concerning our policy can be directed to your reimbursement coordinator at (847) 816-8000

