



DME Plan of Care/Service/Supplies

<u>Compression Garment:</u> Manufacturer: _____ Leg: ___ Arm: ___ Other: ___ (left or right) _____ Compression _____ Size	<u>Blood Glucose Monitor and Supplies:</u> _____ glucose monitor _____ testing strips _____ lancets _____ control solution Testing frequency _____	<u>Ambulatory:</u> Cane: ___ straight ___ 4 prong Crutches: ___ standard Crutches: ___ forearm Walker: ___ 2 wheel Walker: ___ 3-4 wheel Accessories _____ Instruction and fitting: _____	<u>Ostomy Supplies:</u> _____ _____ _____ <u>Urological Supplies:</u> _____ _____ _____
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<u>Orthosis Off the Shelf:</u> <u>Manufacturer</u> _____ right _____ left _____ size(s) <u>Hospital Beds, Mattresses, and other related equipment:</u> _____ caregiver _____ operating instructions	<u>Diabetic Shoes and Inserts:</u> manufacturer _____ size _____ <u>Nebulizers:</u> ___ proper fitting ___ instructions use/cleaning ___ supplies, mask, filters, tubing etc ___ practice using if needed	<u>Surgical Dressings:</u> _____ _____ <u>Breast Prosthesis and Supplies:</u> _____ _____ _____	<u>Other Items:</u> _____ _____ _____ _____ _____
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SAME OR SIMILAR
 Does the patient have same or similar equipment?
 YES ___ No ___

If yes, previous provider _____
 Date purchased/rented _____

Is patient now in a skilled nursing situation?
 YES ___ No ___

If yes, name of Facility _____

Is the patient in the care of a nurse in the home?
 YES ___ No ___

PRINT ALL THAT APPLY FROM HME AND OBTAIN SIGNATURES:

_____ *Advance Beneficiary Notice of Noncoverage (ABN) completed*
 _____ *Assignment of Benefits complete*
 _____ *Rental Agreement*
 _____ *Medical Necessity documentation*
 _____ *Emergency Contact/Caregiver*
 _____ *Medical Release authorization*

I agree that the information provided above is correct. I have been instructed about the use of equipment and supplies and the requirements of Kohll's Rx, applicable insurance requirements, and personal responsibilities. I authorize Kohll's Rx to charge copays, deductibles, or recurring rentals to my credit card.

_____ Signature of Employee _____ Date _____

_____ Signature of Patient (or person acting on patient's behalf) _____ Date _____

Patient's Name Printed _____ Patient Code _____

Emergency Contact: _____ Phone: _____