DME Plan of Care/Service/Supplies

Compression Garment:	Blood Glucose Monitor and Supplies:	Ambulatory:	Ostomy Supplies:
Manufacturer:____________ Leg:___Arm:____Other:______ (left or right) _______Compression _______Size	_______ glucose monitor _______ testing strips ________ lancets ________ control solution Testing frequency________	Cane:____straight _____4 prong Crutches: ____standard Crutches: ____forearm Walker:____2 wheel Walker: ______3-4 wheel Accessories_________________ Instruction and fitting:________	____________________ ____________________ ____________________ Urological Supplies: ____________________ ____________________ ____________________
Orthosis Off the Shelf: Manufacturer __________________________ _________ right ________ left _________ size(s) Hospital Beds, Mattresses, and other related equipment: _________ caregiver _________ operating instructions	Diabetic Shoes and Inserts: manufacturer______________ size ______ Nebulizers: ___ proper fitting ___ instructions use/cleaning ___ supplies, mask, filters, tubing etc ___ practice using if needed	Surgical Dressings: ____________________________ ____________________________ ____________________________ Breast Prosthesis and Supplies: ____________________________ ____________________________ ____________________________	Other Items: ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________

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/Relationship to Patient:

____**Phone:**____________________