

There are five items required in order to process insurance reimbursements:

1. The patient must have paid their yearly deductible (this applies to Medicare reimbursements).
2. Front and back copies of Primary and Secondary Insurance cards.
3. The Patient Information Form filled out, dated, and signed.
4. An Original Prescription stating the specific equipment or service needed (such as Servox, Nu-Vois, or repairs).
5. Payment in full of the desired equipment or any amount not covered by insurance if assignment is accepted.

Lauder Enterprises does not automatically accept assignment. Please call if you have any questions. (We accept checks, money orders, American Express, Discover, MasterCard and Visa).

* To expedite the process, these items can be faxed to us at 210-492-1584, but it is mandatory for you to mail the originals to us for our files.

MEDICARE SUPPLIER STANDARDS

Medicare regulations have defined standards, which a supplier must meet to receive and maintain a supplier number. These standards can be found as part of the Center for Medicare and Medicaid Services (CMS) Law, Regulations, and Manuals under section number 424.57. These standards are listed below.

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program and state healthcare programs, or from any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment. They must also let beneficiaries know about the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage, honor all warranties under applicable state law and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS (formerly HCFA) or its agents to conduct on-site inspections to ascertain the reasonable business hours and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery.
13. A supplier must answer questions, respond to beneficiary complaints and maintain documentation of such contacts.
14. A supplier must maintain, replace at no charge or repair (either directly or through a service contract with another company) any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the names, address, telephone number and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.
21. A supplier must agree to furnish CMS (formerly HCFA) any information required by the Medicare statute and implementing regulations.

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Medicare Champus Group Health Plan HMO

Primary Insurance (Card Number): _____

Secondary Insurance (Card Number): _____

[PLEASE SEND COPIES OF ALL INSURANCE CARDS- FRONT & BACK]

Patient Information

Patient's Name (Last/First/Middle Initial): _____

DOB _____ Marital Status _____ Patient's Sex: Male Female

Patient's Address (address, city, state, zip): _____

Phone: (____) _____

Patient's relationship to insured: _____

Home Hospice Hospital

Insured Information

Patient's Name (Last/First/Middle Initial): _____

Phone: (____) _____ DOB _____

Patient's or authorized person's signature. I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment. I acknowledge my responsibility of any amount not covered by insurance.

Signed: _____ Date: _____

NAME & TELEPHONE NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:

_____ UPIN _____

Patient's Name: _____

Fully describe item or service prescribed (please be specific):

Projected Monthly Frequency: _____

Diagnosis and Prognosis:

Estimated length of need: _____

Date Authorized: _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Physician Unique Provider Number (UPIN): _____ (Do not Omit!)

Physician Signature: _____ Date: _____

ADVANCE NOTICE MEDICARE BENEFICIARY AGREEMENT

If Medicare determines that a particular service, although it would be otherwise covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. In your case, Medicare might deny payment for:

Medicare does not usually pay for this:

- Too many visits or treatments within fixed period of time.
- Service or this amount of services within this period of time.
- Patient is in nursing home, re-hab or facility on date of service in which said facility is responsible for medical necessities. (Patient typically should be at home on date of service.)

Beneficiary Agreement

My provider has notified me that, in my case, Medicare might deny payment for the service(s) checked above. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Beneficiary's Signature

Date
