

SUGGESTED INTAKE FORM

Order taken by:

Date:

Referral person calling in order:

Telephone:

Beneficiary Information

Name:

Date of Birth:

Medicare Beneficiary Identifier (MBI):

Sex: Male Female

Weight:

Height:

Permanent Address:

City:

State:

Zip code:

Telephone:

Name of Legally Responsible Representative:

Relationship to beneficiary:

Street Address:

City:

State:

Zip code:

Telephone:

Ordering Physician Information

Name:

National Provider Identifier:

Street Address:

City:

State:

Zip code:

Telephone:

Specialty:

Is the ordering physician enrolled in PECOS?

Yes

No

Questions for the Beneficiary

Has the beneficiary ever received the same or similar equipment/supplies?

Yes

No

If yes, list equipment/supplies:

Who was equipment purchased/rented from?

Date purchased/rented:

Number of rental months:

Date of previous setup:

Date equipment was returned:

Was item returned to original supplier?

Yes

No

Why was the item returned?

Is the item being replaced?

Yes

No

Is there new medical necessity?

Yes

No

Describe condition for previous need:

Describe new/changed condition:

Is the beneficiary enrolled in a Medicare Advantage Plan?

Yes

No

Has the beneficiary been enrolled in a Medicare Advantage Plan and returning to Fee-For-Service (FFS)?

Yes

No

Has the beneficiary been in a skilled nursing facility or in a home health episode?

Yes

No

If YES, date of discharge?

Questions for the Supplier

If providing repairs on equipment, obtain the following information for the item being repaired:

Manufacturer:

Model Name or Number:

Serial Number:

Purchase Date:

Reason or nature of repairs:

Do you have medical necessity on file for repairs?

Yes

No

Does beneficiary meet criteria for item being repaired?

Yes

No

Is there evidence of continued need on file?

Yes

No

Where will the item be used?

Did I photocopy the Medicare card and/or other insurance cards?	Yes	No
Do I have a standard written order (SWO)?	Yes	No
Does this item require prior authorization?	Yes	No
Do I have supporting documentation on file to meet medical necessity?	Yes	No
Should I obtain an Advance Beneficiary Notice of Noncoverage (ABN)?	Yes	No
What is the primary diagnosis?		
List any other applicable diagnoses:		
Is Medicare the beneficiary's primary or secondary insurer?		
Is the beneficiary or beneficiary's spouse employed?	Yes	No
Is the current condition related to employment, auto, or other accident?	Yes	No
Is the beneficiary nearing Medicare eligibility?	Yes	No
If yes, provide eligibility date:		
Do I need to obtain a one-time authorization form?	Yes	No

Beneficiary Acknowledgement:

Date:

This form provides an example of suggested intake questions. Suppliers may model one to fit their particular type of business. For example, a supplier of oxygen or wheelchairs may need to ask specific questions regarding these policies. This form does not, in any way, replace obtaining an Advance Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the Noridian Medicare website > Browse by Topic tab for information about same or similar equipment, ABNs, and the Limitation of Liability.