noridian
Healthcare Solutions

SUGGESTED INTAKE FORM

Order taken by: Date:

Referral person calling in order: Telephone:

Beneficiary Information

Name: Date of Birth:

Medicare Beneficiary Identifier (MBI): Gender: 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: NPI #:

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, if you are supplying oxygen there may be certain questions you need to ask to oxygen patients. If you are supplying wheelchairs, there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. 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 DME Supplier Manual, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.