KUSTOM KINETICS

OPTUM (UHC)

18 Olmsted St.
Birmingham, AL 35242
Hours: 10am-4pm
Customer Service: 800-313-6468
Fax: 866-637-6864

Rep Name	V. O. Date	P.O. #	Patient SS #	Patient (Last Name, First Name)
Optum #	Secondary INS #	D.O.B. SEX		Facility Name
Additional Insurance - Policy # - Phone# - Address				Ship To Address
Responsible Party - Phone# - Address				Ship to City, State, Zip
DX & ICD10 Code				Therapist/Nurse Attn:
(Diabetic Shoe Qualifying Condition): ICD10				Facility Phone
List any Skin Conditions:	List any Allergies to Materials:			Facility Fax

IS PATIENT CURRENTLY UNDER A SKILLED PLAN OF CARE (SNF PART A) YES_____ NO_____ DATE:

Exisitng Patient ___ New Order ___ Replacement ___ Phone Order ___

Potential for patient to benefit functionally from device: Good_____ Fair_____ Poor_____

Therapy Plan of Care provided for orthotic(s)? Y_____ N_____

Duration of Need:

Is active ROM the plan for treatment? Y__ N__

Is there a non-fixed contracture with at least 10 PROM? Y_ N_

Is the contracture/condition interfering w/patient's functional abilities?Y_Is the expected outcome to Treat & Correct Contracture or Condition? Y_N_

Diabetic Shoes: I am treating this patient under a comprehensive plan of care for his/her diabetes within the last six months. Y_____ N_____

Diabetic Shoes: This patient needs special shoes (depth or custom molded) because of his/her diabetes Y_____ N_____

Circle One Below:

UPS RED **UPS 2ND DAY** **UPS 3RD DAY** **UPS GROUND**

QTY	CODE DESCRIPTION and $	LT	RT	DEVICE DESCRIPTION & NOTES	MODEL #	VENDOR
	HAND code $					
	ELBOW					
	KNEE					
	AFO/BOOT					
	SPINE					
	OTHER					

✓ inventory

HOME HEALTH AGENCY:

RELEASE OF MEDICAL INFORMATION / ASSIGNMENT OF BENEFITS / HIPAA / SUPPLIER STANDARDS

I request that payment of authorized Medicare, Medicaid and/or **Optum (United Health Care)** other private insurance benefits on my behalf be paid directly to MID SOUTH MEDICAL EQUIPMENT, INC for any services furnished to me by MID SOUTH MEDICAL EQUIPMENT, INC. I authorize any holder of medical information about me to release to **Optum (UHC)** the Centers for Medicare & Medicaid Services and it's agents, any information needed to determine these benefits. I acknowledge that I have received a copy of the HIPAA Privacy Practices and the CMS Medicare DMEPOS Supplier Standards.

Statement of Receipt of Product/Attestation of Following Information: Signature at the bottom of this form attests that I or my caregiver have received, read and or been instructed in detail on the following information:

With guidance and/or assistance from a MSME clinician/consultant substantial modifications were made to provide individual fit

RELEASE OF MEDICAL INFORMATION / ASSIGNMENT OF BENEFITS / HIPAA / SUPPLIER STANDARDS

Product as prescribed by my Physician
Copy of my rights and responsibilities as a customer
Upon request a detailed itemized statement will be provided
Instructions on the proper use, care and cleaning procedures of my equipment
Instructed on the Payment process of my equipment
Plan of care and wear schedule has been established by therapy/nursing
Complaint Policy/Emergency contact Information
Satisfaction Survey provide feedback to Supplier
Copy of product warranty
HIPAA Privacy Notice
Medicare Standards
Product for pre-fab Orthotics will be delivered within 5 business days and custom work will arrive in about 4 weeks. If any delays we will notify you

Physician| Nurse Practitioner Name: NPI # PHONE FAX

Physician|Nurse Practitioner SIGNATURE: **Order Date:** **Delivery Date:**