KUSTOM KINETICS

WOUNDCARE LMN

18 Olmsted St.
Birmingham, AL 35242
Fax: 866-637-6864

Hours: 10am-4pm
Customer Service: 800-313-6468

OPTUM (UHC)

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 & ICD 10 Codes:				**Therapist/Nurse Attn:**
DX & ICD10 Code: OTHER				**Facility Phone**
***Start Date*: 30 Day Comprhensive Plan of Care**		***End Date*: 30 Day Comprhensive Plan of Care**		**Facility Fax**

Exisitng Patient ___ New Order ___ Replacement ___ Phone Order ___

Potential for patient to benefit functionally from device:

Good__ Fair__ Poor__

Duration of Need:

Circle One Below:

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

Absent/ impaired sensation in area of contact with seat surface? Y__ N__

Is there a current pressure ulcer or past history of pressure ulcer? Y_ N_ N/A_

Is the condition interfering w/patient's functional abilities?Y_ N_

Is the expected outcome to Treat & Correct or Condition? Y_ N_

QTY	CODE DESCRIPTION				DEVICE DESCRIPTION & NOTES	MODEL #	VENDOR
	E2607/E2608	$275/$380	<22	22>	CUSHION		
	E0197	$200			GRP 1 AIR MATTRESS		
	E0185	$250			GRP 1 GEL MATTRESS		
	E0277	$500/MO RENTAL			GRP 2 AIR MATTRESS		
	E0373	$400/MO RENTAL			GRP 2 NON POWERED		
	E2402	$1500/MO RENTAL			WOUND PUMP		
	A6550	$45			DRESSING		
	A7000	$45			CANISTER		
	OTHER						

✓ inventory

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:

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

Product as prescribed by my physician
Instructed on the Payment process of my equipment
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
The Product has been properly fit and I am satisfied with the equipment
Plan of care and wear schedule has been established by therapy/nursing
Complaint Policy/Emergency contact Information
Follow-up Instructions for Immediate Attention
Satisfaction survey to 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'S/Nurse Practitioner NAME** NPI # PHONE FAX

√ **PHYSICIAN/Nurse Practitioner SIGNATURE** **Order Date:** **Delivery Date:**

1ST WHITE COPY - VENDOR 2ND WHITE COPY - OFFICE YELLOW COPY - REP ALL OTHER PAGES - BENEFICIARY