Thank you for choosing KinneyDrugs® as your pharmacy.

Your Kinney pharmacy has provided you with necessary supplies to help manage your health condition through your Medicare benefits.

For more information on our Medicare Billing program for medical supplies and your patient rights, please visit ***www.kinneydrugs.com/medicarepatientrights*** If you require paper copies of the items below, please ask your Kinney pharmacist.

Here you will find copies of the following:

- Rights and Responsibilities
- Medicare Supplier Standards
- Scope of Services Document
- Complaint Protocol

We would love to know how we did!

Please share your comments by visiting our online customer satisfaction survey.
www.kinneydrugs.com/medicarepatientrights

If you have any questions, please reach out to your local Kinney pharmacy.
If your Kinney is closed, you may reach out to our 24-hour Store at 1-877-306-1973.

KinneyDrugs®

Medicare Billing Patient Packet

Place Rx Label Here

EQUIPMENT

Make & Model: _____ **Lot/Serial #:** _____

TYPE OF PRODUCT

- ☐ Ambulatory products
- ☐ Bath & Safety Products
- ☐ Beds/Patient Room Products
- ☐ Seating products
- ☐ Scooter
- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Orthotics
- ☐ Patient Handling Product
- ☐ Transfer Aids
- ☐ Diabetic Testing Supplies
- ☐ TENS Units
- ☐ Other _____

Warranty: Every product sold or rented by our company carries a manufacturer's warranty. KPH Healthcare Services, Inc. and its affiliates (Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc. and Noble Health Services, Inc.) will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law and will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where the manual is available.

HOME ENVIRONMENT | SAFETY ASSESSMENT

NA - NOT DELIVERED TO HOME

Discuss all appropriate factors and check box if in order.

SAFETY REVIEWED

- ☐ Uncluttered Pathways
- ☐ Safe Operating Equipment
- ☐ Safe Environment
- ☐ Fire Safety Assessed
- ☐ Cords & Adapters
- ☐ Pt/CG Understands Safety Issues
- ☐ Bathroom Assessed
- ☐ Safe Electrical Outlet
- ☐ Area Rugs
- ☐ Getting In & Out of Device

APPROPRIATE FOR HOME

- ☐ YES ☐ NO
- ☐ Alert & Understands Instructions
- ☐ Pt. Confused/Caregiver Instructed
- ☐ Return Demonstration by Patient
- ☐ Note Any Personal/Physical Limits:

  _____

  _____
- ☐ Patient Understands Use of Diabetic Testing Meter
- ☐ DME Item was Checked & in Good Working Order (Confirmed supplies have not expired)

Complaint Protocol: If you are unhappy with the services provided, please call 1 (315) 287-3600 | Option #1. We will respond within 5 calendar days. In the event your complaint is not resolved to your satisfaction you can contact our accrediting organization The Compliance Team at www.thecomplianceteam.org or by calling 1-888-291-5353.

I have been given the patient Welcome Letter that provides a link to access the Patient Rights and Responsibilities, Medicare Supplier Standards, Scope of Services Document, and the Complaint Protocol in addition to the written information/instructions on how to use Medicare covered items safely and effectively: **If patient is unable to sign: authorized person must sign.*

Beneficiary Signature: _____ **Date:** _____

Print Name: _____

Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification

FOR SERVICES ON OR AFTER JANUARY 1, 2006

☐ **I received instructions and understand that Medicare defines the**

_____

INPUT EQUIPMENT PROVIDED

that I received as being either a capped rental or an inexpensive or routinely purchased item.

☐ **For Capped Rental Items:**

EQUIPMENT IN THIS CATEGORY MUST BE RENTED.

- Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

☐ **For Inexpensive or Routinely Purchased Items:**

- Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include: Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.

I choose the: ☐ Purchase Option ☐ Rental Option

Beneficiary Signature: _____ **Date:** _____

Assignment of Benefits (AOB)

THIS AOB FORM IS REQUIRED TO BILL ON YOUR BEHALF!

My signature and date in the box below authorizes each of the following:

EQUIPMENT IN THIS CATEGORY MUST BE RENTED.

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc., for medical supplies and/or medication(s) furnished to me by KPH, Inc.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc. to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc. to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

☐ **I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.**

Beneficiary Name: _____ **Your Phone #:** (____) _____

PRINTED

Beneficiary Signature: _____ **Date:** _____

☐ I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to KPH Health Services, Inc. and/or any of our corporate affiliates Kinney Drugs, Health Direct Institutional Pharmacy Services, Inc., or Noble Health Services, Inc. for any medical supplies and/or medications furnished to me by KPH Inc. I authorize any holder of medical information about me to release to KPH, Inc., my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

YOUR MEDICARE #

☐☐☐☐–☐☐☐–☐☐☐☐ **Insurer Phone #:** (____) _____

Insurer: _____ **Policy #:** _____

(OTHER THAN OR IN ADDITION TO MEDICARE)

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