PATIENT INTAKE SHEET

DATE: ____________________ TIME: ____________ EMPLOYEE: ______________________

☐ DELIVERY	☐ PICKUP	☐ REPAIR	☐ SWITCH
☐ FACILITY:		☐ HOSPICE:	
☐ HOSPITAL:		☐ MEDICARE/PRIVATE INSURANCE	

CUSTOMER INFORMATION			
CALLER NAME:		CALLER PHONE:	
PATIENT NAME:		ROOM #:	BED #:
PATIENT/FACILITY ADDRESS:			
CITY:	STATE:	ZIP:	PHONE #:
D.O.B.:	SSN:	HEIGHT:	WEIGHT:
ALTERNATE CONTACT:		RELATIONSHIP:	PHONE #:
PO #:	CREDIT CARD TYPE:	CREDIT CARD #:	EXP DATE:
ANTICIPATE DISCHARGE DATE:		LENGTH OF NEED:	

HCPC CODE	PRODUCT	DX	HCPC CODE	PRODUCT	DX

INSURANCE INFORMATION	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
POLICY #:	POLICY #:
GROUP #:	GROUP #:
PHONE #:	PHONE #:
EFFECTIVE DATE:	EFFECTIVE DATE:

PHYSICIAN INFORMATION		
ORDERING PHYSICIAN:	PHYSICIAN PHONE #:	
UPIN #:	PHYSICIAN FAX #:	
PHYSICIAN ADDRESS:		
CITY:	STATE:	ZIP:

*ALL SHADED AREAS ARE TO BE COMPLETED FOR MEDICARE/PRIVATE INSURANCE CUSTOMERS

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INSURANCE VERIFICATION FORM		
NAME OF INSURANCE REP:	DATE:	TIME:
DOES THE PATIENT HAVE INSURANCE WITH YOU? ☐ YES ☐ NO EFFECTIVE DATES OF INSURANCE:		

DOES THE PATIENT HAVE DME COVERAGE? ☐ YES ☐ NO	IS THERE A DEDUCTIBLE? ☐ YES ☐ NO
AMOUNT OF DEDUCTIBLE: $	HAS DEDUCTIBLE BEEN MET? ☐ YES ☐ NO
IS PRIOR AUTHORIZATION NECESSARY? ☐ YES ☐ NO	Auth #:
CONTACT NUMBER FOR AUTH:	HAS LIFETIME BENEFIT BEEN MET? ☐ YES ☐ NO
DOES THE INSURANCE FOLLOW MEDICARE GUIDELINES? ☐ YES ☐ NO	

SAME OR SIMILAR EQUIPMENT
**These questions should be asked to patient, caregiver, family, or emergency contact to assist in determining reimbursement
HAS PATIENT EVER HAD MEDICAL EQUIPMENT IN THE PAST? ☐ YES ☐ NO CIRCLE: RENTED OR PURCHASED
IF SO, LIST:
WHEN DID PATIENT HAVE EQUIPMENT?
NAME / LOCATION OF COMPANY THAT SUPPLIED EQUIPMENT:

LAB DATA	
OXYGEN DATA	**CPAP DATA**
PaO_2 mmHg OR SaO_2 % via ABG	☐ SLEEP STUDY IS PENDING:
SPO_2 % via Pulse Oximetry	☐ SLEEP STUDY ON FILE:
TEST DATE:	SLEEP STUDY PERFORMED AT:
TEST FACILITY:	OTHER (LIST BELOW):

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