

Patient Assessment for Arthritis or Joint Pain

Assessor Name: _____

Phone: _____

Patient Name: _____ DOB ____/____/____

Are you experiencing Arthritis or Joint Pain? Yes No Have you seen your doctor about it? Yes No

Do you have Osteo Arthritis (OA)? Yes No Do you have Rheumatoid Arthritis (RA)? Yes No Ever Injured? Yes No

Brief Description? _____

When were you last seen by your doctor for this condition? _____ More than 4 months requires a doctor visit to process

Where do you hurt, and which Products are you requesting?

<p>Wrist and Hands Pick one per hand</p> <p>L3912 Arthritic Gloves Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Size: _____"</p> <p>L3908 Carpal Tunnel Glove: Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Size: _____"</p> <p>L3807 Carpal Tunnel with Thumb Spica (splint protects the thumb) Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Size: _____"</p> <p>L3908 Wrist Forearm Splint (extends up the forearm) Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Size: _____"</p> <p>L3908 Brace with Dorsal Stay (stay top and bottom of wrist removable) Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Size: _____"</p> <p>Gloves: Measure Around Hand: _____"</p> <p>All others: Measure Around Wrist: _____"</p> <p>L0631 THERMOSKIN RIDGID BACK Worn under clothing <i>Low back pain, sciatica, stenosis. Degenerated, bulging, herniated discs</i> Measure below naval around back: _____"</p>	<p>L1845 Ossur Unloader One Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH OSTEO-ARTHRITIS OFF-LOADS BONE OFF BONE Rehabilitates Quads Bone on Bone Inside Knee (Bowlegged) Varus? Yes <input type="checkbox"/> No <input type="checkbox"/> Size: _____"</p> <p>Thigh Circumference: 6" above mid-patella Calf Circumference: 6" below mid-patella</p> <p>OR Bone On Bone Outside Knee (Knock Knee) Valgus? Yes <input type="checkbox"/> No <input type="checkbox"/> Size: _____"</p> <hr/> <p>L1832 KNEE THERMOSKIN Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH Measure below Patella (Knee Cap) around knee</p> <p>L1832 Ossur ROM Hinge Short Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH Circumferential measurement: 6" above mid-patella. Rheumatoid Arthritis Injures, Ligament Injuries Stabilization, Increase Circulation Left Knee _____" Right Knee _____"</p> <hr/> <p>L0631 Ossur Miami Lumbar Yes <input type="checkbox"/> No <input type="checkbox"/> L0637 Ossur Miami Lumbar lateral support Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Low back pain, sciatica, stenosis. Degenerated, bulging, herniated discs</i></p> <hr/> <p>L0631 Stealth Pro Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Low back pain, sciatica, stenosis. Degenerated, bulging, herniated discs</i> Measure below naval around back: _____"</p> <hr/> <p>L3760 ELBOW Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Thermoskin Hinged Rom Measure around Elbow: _____"</p>
<p>L1902 AFG STABILIZER THERMOSKIN, Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Indoor Slippers, Neuropathy. Increases Circulation Shoe Size: _____"</p>	<p>L4360 Aeris Walking Boot Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH Dual Air Chambers for custom fit Pre/post Surgery, sprains, fractures Shoe Size: _____"</p>
<p>L1906 Arch Lok Ankle Support ALL ACTIVITY Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT <i>Poor Arches or Flat Feet</i></p> <p>L1902 Easy Lok Ankle Support LIGHT ACTIVITY Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT</p> <p>L1902 Tarsal Lok Ankle Support HIGH ACTIVITY Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT Shoe Size: _____"</p>	<p>L4396 Adj Night Splint Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH Plantar Fasciitis & Achilles Tendonitis – Cramp bottom of feet when waking up? Shoe Size: _____"</p>
<p>E0143 E0156 Rollator Wheeled Walker with Seat assembly required by rep Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>E0628 Electric Lift Seat, assembly required by rep, cannot stand up without assist</i> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>L1971, L2210 Step Smart Solution for Drop Foot! Yes <input type="checkbox"/> No <input type="checkbox"/> LT RT BOTH Shoe Size: _____"</p>
<p>L3650 Clavicle Support (Fracture or Deformity of the Clavicle/Collar Bone) Yes <input type="checkbox"/> No <input type="checkbox"/> Chest: _____"</p>	<p>L7900 ED Battery <input type="checkbox"/> Manual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Call your doctor's office and let them know that you are still experiencing these problems and ask for these products. **Notes:**

Patient or Authorized Persons Signature: I am requesting the products listed "Yes" above, and authorize the release of any medical information necessary to process this claim. I was not cold call telemarketed, door knocked, or inappropriately solicited for this product. I have received and understand Patient Bill of Rights, Privacy Notice, Medicare DMEPOS Supplier Standards, and warranty coverage on the products I have received.

Signature: _____ Date: ____/____/____



SS MEDICAL SUPPLY

Durable Medical Equipment Prosthetics Orthotics Supplier

501 S, Falkenburg Road, Suite E18&19, Tampa, FL 33619 Office:800-657-4090 Fax:-866-626-7881

Patient name: _____

As spelled on Medicare Card

Medicare # _____

Use Social Security Number if not on Medicare

PATIENT CONSENT

I certify the information given by me in applying under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about me to release it to the Center for Medicare and Medicaid Services or its agents any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for services of SS Medical Supply to be paid to SS Medical Supply or authorize SS Medical Supply to submit a claim to Medicare for payment for me. Assignment of Medicare claims does not mean that Medicare pays your entire bill. Patient's responsibility on assigned Medicare claims includes payment of:

- Annual Medicare deductible
- 20% co-insurance on approved services
- Non-covered services
- Services rendered under a waiver of liability, approved, but not paid by Medicare

I hereby acknowledge that I have been given a copy of the "Privacy Notice". This notice describes how health information may be used and disclosed and how a patient can get access to their health information. I have been advised by SS Medical Supply to read this document and to forward any questions to their Compliance Officer at 800-657-4090.

I certify that I have been instructed and understand the complaint and warranty policy as well as the customer instruction for use.

- I have read and consent to receiving** information on the products supplied.
- I have read and consent to receiving** the Supplier Standards.
- I have read and consent to receiving** the Patient Bill of Rights.
- I have read and consent to receiving** notification of how to voice a complaint.
- I have read and consent to receiving** Equipment Warranty and Return Policy.
- I have read and consent to receiving** the Patient Grievance Letter.
- I have read and consent to receiving** the Mission Statement from SS Medical Supply
- I have read and consent to receiving** the Patient Satisfaction Survey.

I authorize any holder of medical information about me to be released to SS Medical Supply or my insurance carrier any information necessary to determine benefits and payment. I permit a copy of this authorization to be used in place of the original.

Signature of Patient: _____ Date: _____

Assessor Name: _____

Phone: _____

FAX TO: 866-686-7881

BILLING INTAKE FORM
 SS Medical Supply
PLEASE PRINT LEGIBLY!

Assessor

Name:

Phone:

PATIENT NAME: LAST:			FIRST:		M:
DOB	MALE	FEMALE	HEIGHT	WEIGHT	Emergency Contact:
	<input type="checkbox"/>	<input type="checkbox"/>	' "	LBS	
*PATIENT ADDRESS per MEDICARE				DOES THE PATIENT HAVE AN OUT OF STATE ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO SHIP TO:	
STREET:			STREET:		
CITY:		STATE:		CITY:	
ZIP:		PH:	ALT PH:	PHONE:	

PHYSICIAN INFORMATION * NPI NUMBER OBTAINED AT www.hmedata.com *****

NAME:	DX:	DX:	DX:	DX:	DX:
STREET:					
CITY:				STATE:	ZIP:
PHONE:	Fax:	NPI:			

INSURANCE INFORMATION. IF MEDICARE ONLY, ALL WE NEED IS MEDICARE NUMBER

<i>Always fill in Medicare Claim Number to the right, don't forget the letter after the number!:</i>	MEDICARE #:
PRIMARY INSURANCE (ONLY IF Medicare Advantage, PPO, PFFS, or HMO) What type is it? FILL IN EVERY SPACE	Secondary/Supplement/Medi-Gap/Medicaid/Tricare
PHONE# of INS CO:	PHONE #:
NAME of INS CO:	NAME:
ADDRESS:	ADDRESS:
CITY:	CITY:
STATE:	STATE:
ZIP:	ZIP:
MEMBER ID #:	ID #:
GROUP or Policy#:	GROUP#:

PLEASE FILL IN EACH ITEM AND SIZE ORDERED BELOW:

HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>
HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>
HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>
HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>
HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>
HCPCS CODE/DESCRIPTION	QTY	SIZE	<u>LT/RT</u>

Item Code is HCPCS Code listed on Patient Assessment Sheets, Include Description and Size (S, M, Lg etc.)



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Durable Medical Equipment Prosthetics Orthotics Supplier

501 S, Falkenburg Road, Suite E18&19, Tampa, FL 33619 Office. 800-657-4090 Fax: 866-626-7881

New Order : SS Medical Supply Fax Cover Page: Needs Rx OR Complete w/ Rx

Assessor name: _____ Patient Name: _____

Assessor Phone: _____ Patient Phone (____) ____ - _____

E-Mail: _____ Patient DOB ____ / ____ / _____

Physician : _____

Physician Phone: (____) ____ - _____ Physician Fax: (____) ____ - _____

Fax To: 866-626-7881 One Order Per Fax!

*****i.e. If you have 5 patients, send 5 faxes!*****

Date faxed: ____ / ____ / _____

New Prescription Order contains a minimum of 4 pages including this Cover Sheet:

- | | |
|--|--|
| | 1. Patient Assessment Form(s) w any notes |
| | 2. Billing Intake Form Ensure you have accurate and complete billing information! |
| | 3. Signed Patient Consent Form |
| | _____ has called Physician's office and has received their permission to fax a DME request for the above patient |
| | Send fax attention to: _____ |
| | Optional for Rep to obtain, but mandatory to complete order: |
| | Physician's Prescription forms signed (CMN's) (optional, we will do for you) |
| | Patients Clinical or Progress Notes from the Physician (optional, we will do for you) |



L3807 THERMOSKIN Carpal Tunnel with Thumb Spica, protects Thumb



L3908 THERMOSKIN CT Glove Covers fingers and Wrists. Removable Brace.



L3908 THERMOSKIN Wrist Forearm Splint Covers Forearm



L3908 Brace with Dorsal Stay for Immobilization option. BRACE on top and bottom, removable.



L1845 SWEDEO OA OFF LOADS WITH AIR, WON'T MIGRATE AND REHABILITATES THE QUADS! Off The shelf



L1832 THERMOSKIN KNEE Increases CIRCULATION RA, Ligaments, Injury, Won't Migrate



L3760 THERMOSKIN ELBOW Hinged ROM, Increases Circulation



L0631 THERMOSKIN APD RIGID LUMBAR SUPPORT, Critical Support to back and abdomen, the ONLY brace worn against skin and increases circulation!



ED Pump L7900



E0143 & E0156 Wheeled Walker with Seat, adjustable handle bar height, nice seat and carry basket



E0628 Electric Lift Seat for those who cannot stand up on their own, but can walk after standing.



L3650 Clavicle Support Broken, Fractured, or deformity in Collar bone? Provides support and conditioning for the clavicle.



L1906 Arch Lok

Rigid Brace, strongest active wear support, worn inside shoe. Hinged Style Brace. Weak Ankles, Foot and Arch Support, Poor Arches, Flat Feet. **Rehabilitates recently injured ankles. ALL ACTIVITY**

The Arch Lok is a hinged style brace with a modified orthotic footplate. The footplate provides critical foot and arch support to help rehabilitate a recently injured ankle. **Ideal for poor arches or Flat Feet**



L1902 Easy Lok **NEW!**

Soft Brace, worn inside shoe. Velcro Straps easy on the hands and fingers.

The adjustable closure straps make this brace very easy to use. Simply slip on the brace, secure the straps, and enjoy excellent ankle support. Ideal for arthritic patients and those who have a difficult time securing a traditional lace up style. **LIGHT ACTIVITY**



L1902 Tarsal Lok **NEW!**

Soft Brace, worn inside shoe, for the active lifestyle.

"Best of Both Worlds" Combines the support of a rigid brace with the comfort of a lace up brace. Patented built in stabilizer actually molds to the shape of your ankle from body heat. **HIGH ACTIVITY**



L1902 AFG STABILIZER

THERMOSKIN, TRIOXON Soft Brace, Indoor Use, Sleep with them, wears like house slippers, **worn directly against skin, not over socks.**

Ideal for **Diabetes**, Arthritis, Reynaud's Disease, & other ailments. Helps relieve the "burning sensation" associated with Diabetic Neuropathy. Increases Circulation and stabilizes the ankles.



L4360 Aeris Walking Boot Dual air chambers positioned medial / lateral at the ankle can be inflated and deflated for ideal compression and a custom fit. Designed for the treatment of stable fractures, ankle sprains, or fascia.

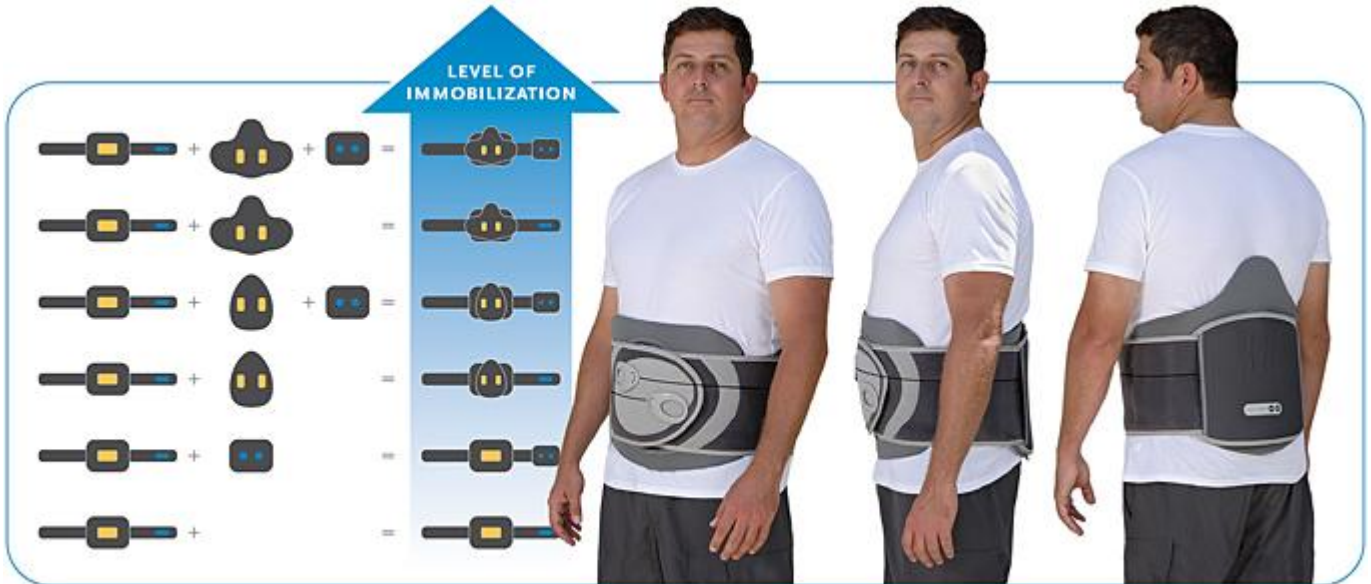


L1971, L2210 Step Smart Solution for Drop Foot!

No need to increase shoe size! Not only designed for clearance during the swing phase, it is also engineered to handle shock absorption at heel strike. The exclusive Jacob Joint (pictured above right) pushes the foot into gentle dorsiflexion during swing phase.



OSSUR PRODUCTS



Photos depict the highest level of immobilization: Miami Lumbar belt plus a pendulous anterior panel plus a posterior panel with lateral supports

MIAMI LUMBAR L0631 and L0637 codes



UNLOADER ONE OTC (over the counter)
L1845 code



STANDARD ROM (range of motion) Short Wrap (bottom row only)
L1832 code