Pro Medical East LLC
A GARDEN STATE MEDICAL SUPPLY COMPANY

PROVIDER Rx & PATIENT PRODUCT AGREEMENT

PATIENT INFORMATION

NAME _____ ADDRESS _____ CITY _____ STATE ___ ZIP _____

INSURANCE _____ NUMBER _____ PHONE _____ SEX ___ DOB _____

PHYSICIAN INFORMATION

PHYSICIAN _____ NPI # _____

By my signature, I am prescribing the item(s) listed below. In my judgement, the below item(s) is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

SIGNATURE _____ DATE _____

APPROVED SERVICES

☐ RIGHT ☐ LEFT SIZE _____

A: ITEM

☐ **L1902** | Ankle gauntlet
☐ **L4361** | Walking Boot, Pneumatic
☐ **L1906** | Ankle Brace Multiligamentus
☐ **L4387** | Walking Boot, Non-Pneumatic
☐ **L3260** | Surgical Boot/Shoe
☐ **L1930** | AFO, Prefabricated Plastic
☐ **L4350** | Air/Gel Stirrup Ankle Brace
☐ **L1971** | AFO w/ Ankle Joint
☐ **E0114** | Crutches
☐ **OTHER** _____

B: CONFIRM

☐ Patient is ambulatory with weakness or deformity of the foot and ankle requiring stabilization for Medical reasons and has the potential to benefit functionally.

A: ITEM

☐ **L4397** | Padded Night Splint / Podus Boot

B: CONFIRM

☐ Patient is non ambulatory or minimally ambulatory.
☐ Item has been fitted for patient by orthotist or individual with specialized training.

C: DOES PATIENT MEET ONE OF THE FOLLOWING COVERAGE CRITERIA

☐ Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing (using Goniometer) of at least 10 degrees. AND Reasonable expectation of the ability to correct the contracture AND Contracture is interfering or expected to interfere significantly with the beneficiary's functional abilities AND Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.
☐ Patient has Plantar Fasciitis.

DIAGNOSIS

CONTRACTURE OF ANKLE
☐ **M24.572** | Left ☐ **M24.571** | Right

CONTRACTURE OF FOOT
☐ **M24.575** | Left ☐ **M24.574** | Right

PRIMARY OSTEOARTHRITIS OF ANKLE
☐ **M24.572** | Ankle LT ☐ **M24.571** | Ankle RT

PRIMARY OSTEOARTHRITIS OF FOOT
☐ **M24.575** | Foot LT ☐ **M24.574** | Foot RT

OTHER DERANGEMENT OF ANKLE
☐ **M24.872** | Left ☐ **M24.871** | Right

FOOT DROP
☐ **M21.372** | Left ☐ **M21.371** | Right

POSTERIOR TIBIAL TENDONITIS: LEG
☐ **M76.822** | Left ☐ **M76.821** | Right

PERONIEAL TENDONITIS: LEG
☐ **M76.72** | Left ☐ **M76.71** | Right

OTHER DERANGEMENT OF FOOT
☐ **M24.875** | Left ☐ **M24.874** | Right

FLEXION DEFORMITY: ANKLE & TOES
☐ **M21.272** | Left ☐ **M21.271** | Right

OTHER
_____
_____

PLACE BARCODE LABEL HERE
PRODUCT #1

PLACE BARCODE LABEL HERE
PRODUCT #2

PLACE BARCODE LABEL HERE
PRODUCT #3

I have been educated and instructed on the proper use of the medical equipment above for use at home according to the physician's description for my condition. The Following Has Been Explained/ Reviewed With Patient: Equipment use instructions ▪ Costs and reimbursement ▪ Home safety & home fire safety ▪ Complaint process ▪ Patient rights & responsibilities Notice of privacy practices (HIPAA) ▪ Infection prevention and control ▪ Patient satisfaction ▪ Patient falls education ▪ Policy notification ▪ Victim abuse ▪ CMS standards

ASSIGNMENT OF BENEFITS: I confirm that the information provided by me in applying for payment under Title XVIII (Medicare) of the Social Security Act and any other named insurance is true and correct. I request payments under my medical insurance program be made to Pro Medical East or its affiliates Inc. on any unpaid bills for services furnished to me by Pro Medical East or its affiliates Inc. I certify that the address indicated under "customer name" is my permanent address as defined by the Centers for Medicare and Medicaid (CMS). INSURANCE COVERAGE: Benefits are based on insurance eligibility and coverage at the time of service. RELEASE OF INFORMATION: I authorize any holder of medical or other related information about me be released to Pro Medical East or its affiliates Inc and its agents for the purpose of determining benefits for related services and applying for payment. I authorize Pro Medical East or its affiliates Inc. to release to CMS, its intermediaries, or commercial insurance companies and accrediting bodies' information needed for insurance claims in quality assessment purposes. This agreement consists of all the terms and conditions on this page and the reverse side whether printed or written. I certify that I have read the terms and conditions of this agreement and agree to be bound by such provisions. I accept full responsibility for all services rendered, including being informed of my rights, responsibilities, and complaint procedure. I have also been instructed on the safe and proper use of the equipment and/or supplies provided and agree to notify Pro Medical East or its affiliates Inc immediately when the medical necessity has ended. I have received or previously received a copy of Medicare Supplier Standards, Patient Bill of Rights, HIPAA Privacy Rights and a Customer Handbook from Pro Medical East or its affiliates Inc.

I, THE UNDERSIGNED, UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. _____ initial

PATIENT / CARE GIVER NAME _____ PATIENT / CARE GIVER SIGNATURE _____ DATE _____

(If signed by caregiver or other, list relationship and reason for signing)

CHECK ONE ☐ CARE GIVER ☐ RELATIVE ☐ OTHER _____ TIME _____

IN THE EVENT OF A GRIEVANCE I UNDERSTAND I HAVE THE RIGHT TO COMMUNICATE THOSE GRIEVANCES TO CMS MEDICARE 1-800-MEDICARE

1995 RUTGERS UNIVERSITY BLVD, LAKEWOOD NJ 08701 ▪ PHONE: _____ ▪ FAX: _____ ▪ EMAIL: _____