# REHAB SERVICES, LLC

Patient File Checklist

Patient Name_____

- ✓ Certificate of Medical Necessity or Rx on file within 30 days
- ✓ Emergency contact name and phone number_____
- ✓ Diagnosis
- ✓ Insurance Information (insurance name, policy #, name of insured)
- ✓ Delivery Ticket including:
  - Patient name, address and phone number & Item(s) delivered and Serial number
  - Date item(s) delivered and/or Start Date & Signature of patient or family
- ✓ Patient Infection – Airborne (TB) - __NO__
- ✓ Information left with patient:
  - Mission Statement & Business contact information and after hours contact
  - Complaint process & Patient rights/responsibilities/HIPPA
  - Assignment of benefits and release of information
  - Supplier Standards (Medicare)
  - Terms of Rental Agreement / Warranty / Replacement information
  - Community Resources information & Written cleaning instructions
- ✓ Home Safety Assessment
  - Recommendation for any safety issues_____

- ✓ **Financial Policies and Benefit Information**
  - Estimated co-insurance amount patient may be responsible for based on insurance benefits:_____
    Please Note: Benefit information given is not a guarantee of payment from your insurance company. Benefits are subject to all contract limits and the member's status on the date of service.

  - If your insurance carrier does not cover based on their medical policy or denies your claim, our rates are outlined below. If this happens, we encourage you to contact your insurance company on your own behalf to appeal.

    - **CPM RENTAL: $350** flat fee for up to 21 days. **$15** per day after the initial 21 day rental period.

    - **OTHER:**_____

**If we feel that your insurance carrier may not pay for your claim based on their medical policy we will ask for a check or credit card to pre-pay for the rental/purchase of our medical devices. We will still file a claim with your insurance carrier for the services/items that you have received. If your insurance denies the claim, you are responsible for any appeals. If the insurance ultimately pays the claim we will send you a refund check minus any coinsurance and/or deductibles. Please allow 2-3 weeks after the date of the insurance payment to receive your refund. In the event that your insurance carrier denies coverage for the Sheepskin Pad used with the CPM Machine (where applicable), we charge $20. All coverage and allowables will all be outlined in your Explanation of Benefits (EOB). Your EOB from your insurance should also outline your rights to appeal the denial and we encourage you to follow through with the appeal. For any additional clarification on this please call our office, 800-486-KNEE.**

Credit Card Information Form

Name on Card:_____ Card Number:_____

Exp. Date:_____ 3 Digit Code:_____ Email (for receipt):_____
(4 digit on front for AMEX)

_____ _____

**Signature** **Date** **Representative's Signature** **Date**