1901 NORTH MAIN STREET
ANDERSON, SOUTH CAROLINA 29621
(864) 224-0711 (800) 256-6017
www.bryantRx.com

INTAKE AND PLAN OF SERVICE

EIN: 570 445533 / Medicaid DME504 / NSC 0331070001

The information we obtain to complete claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered and to insure that proper payment is made.

☐ Photo I.D. presented (if no, explain) ____________ ____________ ____________

Patient:____
F MI L

Address: ____

Mailing Address (if different)____

Phone #: (______) ________-_______________Date of Birth____/____/____ Sex M__F__ Height (in)_______Weight (lbs)_______

Patient SS#: ________-______-________________ *Guarantor (If covered under another's policy)* ________________________________

Guarantor's Address: ____

Phone #: (______) _________-_________________Date of Birth____/____/____ Sex M____F____

Emergency Contact __________________________Relationship) ________________________Phone #: (_____) ________-_________________

Primary Coverage* (______________________)
__Medicare __Medicaid __Other*
Group Number_________________________________
Policy Number_________________________________

Secondary Coverage (_____________________)
__Medicare__Medicaid__Other*
Group Number______________________________________
Policy Number______________________________________

*If not Medicare or Medicaid, list Company Name, Address, & Phone #

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HOME ASSESSMENT-ENVIRONMENTAL/SAFETY

ARCHITECTURAL BARRIERS	❑ ADEQUATE	❑ INADEQUATE	❑ *N/A PICKED UP IN-STORE*
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING	❑ ADEQUATE	❑ INADEQUATE	❑ *N/A DEL TO:* ______________
ELECTRICAL (CHECK GROUND, NO USE OF EXTENSION CORDS)	❑ ADEQUATE	❑ INADEQUATE	
FIRE SAFETY (HAS SMOKE DETECTOR/ALARM AND EXTINGUISHER)	❑ ADEQUATE	❑ INADEQUATE	

DOES ANYONE SMOKE IN THE HOME? ________________________ANY SAFETY OR HEALTH HAZARDS AND COMMENTS;_________________________
____

PLAN OF SERVICE: Identified Needs/Problems: The client is unfamiliar with use and maintenance of the home medical equipment. Expected Outcomes: The client will be provided prescribed equipment to comply with the physician's prescription. The client will use the home medical equipment as prescribed by the physician. The client will use and maintain home medical equipment in a safe/proper manner. The client will know how to obtain follow-up services as needed. Services/Actions Provided: Deliver and set-up home medical equipment at a mutually agreed upon time and place. Provide training in safe/proper use and maintenance of all home medical equipment. Provide training and written handout in client rights and responsibilities, supplier standards, home safety, HIPPA Privacy standards, emergency planning and provide financial responsibilities. Demonstrate troubleshooting of equipment and correct use of back-up system (if provided).

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process any claims for services provided to me. I also request payment to myself or to Bryant Pharmacy & Supply when assignment is accepted. I have been provided a copy of the Medicare Supplier Standards, as well as equipment warranty information where applicable. I understand that Medicare Rental Equipment (excluding oxygen) will be considered purchased after 13 months. Oxygen will be capped after 36 consecutive months of rental. I will accept financial responsibility for any deductibles, co-payments, or claim denials. Account balances will be billed for 3 months. Accounts with no payment activity will then be forwarded to a collection agency.

Signed:____**Date**:__________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **I have received a copy of the HIPAA Notice of Privacy Practices and the Protocol for resolving complaints.**

Signed:____**Date:**______________________________

(Relationship to patient)______________________________ **Reason patient did not sign**____________________________