



At AlphaMed we try to provide each client with the product and equipment that he or she needs. However, some insurance policies will not cover all equipment that may be ordered. Please print and read this packet for a general list of covered and non covered items. Each insurance policy is different, and it is impossible to know until we submit your order to the insurance provider what will be covered. Thank you for giving us the opportunity to serve you and if we can be of any other service please contact us using the contact information provided in this packet.





AugComm Device Checklist

1. Signed physician Rx for devices or accessories needed
2. Letter of Medical Necessity or Speech Evaluation
3. Client Demographics that include: Name, DOB, Address(No PO boxes for shipping reasons), Insurance Information(Copy of cards if possible), Working phone numbers, physician name.
4. Quote for equipment from AMDI.

If you do not have a signed Rx please print off the one included in this packet and have the physician sign.



Ph (731) 660-0060 Fax (731) 660-0622

Showroom: 935 Old Humboldt Rd, Ste A, Jackson, TN 38305
Send Mail To: PO Box 10728, Jackson, TN 38308

Augmentative Communication Device

Patient Info/Insurance Data

Ph: (____) _____ DOB: _____

HICN: _____

Physician Contact Info/NPI

Office#: (____) _____ Fax: (____) _____

NPI: _____

Narrative Description of Equipment and Cost

Manufacturer	QTY	HCPCS	Description	CHG (Office Use)	Allow (Office Use)

1. Length of need _____ 99=lifetime

2. Diagnosis/Conditions: _____

Physician Signature: _____ Date: _____

Physician Printed Name _____ NPI _____



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Sample RX

Augmentative Communication Device

<p style="text-align: center;"><u>Patient Info/Insurance Data</u></p> <p style="text-align: center;">John Smith</p> <hr/> <p style="text-align: center;">999 Old Oak Street</p> <hr/> <p style="text-align: center;">Jackson Tn 38305</p> <hr/> <p>Ph: <u>(731) 660-0060</u> <u>DOB:4/1/66</u></p> <p style="text-align: center;">HICN: <u>410879809A</u></p>	<p style="text-align: center;"><u>Physician Contact Info/NPI</u></p> <p style="text-align: center;">John Smith M.D.</p> <hr/> <p style="text-align: center;">184 Maple Cove</p> <hr/> <p style="text-align: center;">Jackson Tn. 38305</p> <hr/> <p>Office: <u>(731) 660-0060</u> Fax: <u>(731) 660-0622</u></p> <p style="text-align: center;">NPI:<u>123456789</u></p>
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Narrative Description of Equipment and Cost

Manufacturer	QTY	HCPCS	Description	CHG	Allow
AMDI	1	E2500	Tech Talk 8	460.00	410.20

1. Length of need 99 99=lifetime

2. Diagnosis/Conditions: Mental Retardation Developmental Delay

Physician Signature: _____ Date: _____

Physician Printed Name: _____ NPI: _____



Items Usually Not Covered by Insurance

- **Mounting systems(for table,beds,chair)**
- **Carry Cases(Covers)**
- **Extended Batteries**
- **Tech Caps**
- **Manuals**
- **Overlays**

In most cases only the devices themselves are covered items. We will always submit all products to be covered and will always contact the person placing the order to discuss any non-covered items.



SALES & RENTAL DELIVERY INVOICE

Date & Time of Delivery: _____ Date & Time Notified of Request: _____

CUSTOMER INFORMATION

BILLING INFORMATION

Name: _____
 Address: _____
 City: _____ St: _____ ZIP _____
 Phone: _____
 SSN: _____
 DOB: _____ Diagnosis: _____
 Physician: _____

Primary Insurance: _____
 Secondary Insurance *: _____
*(*if no 2ndary, complete Co-Ins Form supplied in this packet)*
 Recent Insurance change? _____
 If Medicare pt, is pt enrolled in an HMO? _____
 If yes, name of HMO: _____
 Is pt in PPO? _____
 If yes, auth#: _____ exp: _____

QTY	DESCR	ITEM #/ SERIAL #	HCPCS	CHRG or PYMNTS	DETAILS
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase
					Rental Purchase

Payments Reflect: () Retail Sale () Private Purchase () 20% Member Portion

Comments: _____

**Plan of Service Acknowledgement
Terms and Conditions**

Proof of Delivery, I acknowledge receipt of the above equipment in clean and good working order. I have received Training Materials for safe and proper use of the equipment, including cleaning and maintenance. I have received a copy of AlphaMed's HIPAA Standards, CMS Supplier Standards, Patient Rights and Responsibilities, and AlphaMed's Scope of Services.

Assignment of Benefits, I authorize release of Medical Information as necessary to justify the need for medical equipment and authorize payments to be paid directly to AlphaMed, Inc. I agree, whether I sign below as agent or patient, to accept all financial responsibility for the medical equipment furnished to me or the patient by AlphaMed, Inc. A copy of this agreement may be used in place of the original.

Sales and Rentals, All sales are Final. No refund on purchased or early return of rental equipment.

Patient or Authorized Rep* Signature: _____ Date: _____

* If other than patient is signing, state reason & relationship to Patient: _____

Delivered by: _____ Date: _____

Please fax to: 731-668-2250