PATIENT AGREEMENT / DETAILED WRITTEN ORDER

For Billing: Please call 888-351-4524

Call _____ if you have questions, concerns, or suggestions about our equipment or service.

№ 89143

PATIENT INFORMATION

Female ❑ Male ❑

Name _____
First M Last

Mailing Address _____

_____
City State Zip

Hm # _____ Wk # _____

DOB _____ SSN _____

EMAIL _____
(For Access To Payment Portal)

DETAILED WRITTEN ORDER

_____
Verbal Order Date

Practitioner _____

NPI # _____

Phone # _____

ICD 10 _____

Practitioner Signature: _____ Date: _____

By my signature, I am prescribing the item(s) listed. In my judgment the prescribed item(s) is medically indicated, necessary and consistent with the current accepted standards of medical practice and treatment of patient's physical condition. A qualified individual has performed the proper fitting, adjustment and education of the product(s) with the patient.

Left ❑ Right ❑ *Medicare Requires An Original Signature*

MEDICARE

Primary ❑ Secondary ❑

Medicare # _____

Name on Card _____

INSURANCE INFORMATION

Insurance Carrier _____

Insured's Name _____

Relationship to Patient _____

ID # _____

Benefits/Eligibility Phone # _____

Adjuster/Contact _____

DOI _____

MEDICARE: Primary ❑ Secondary ❑

Surgery Date ____/____/____ CPM Applied Hosp Date ____/____/____

Hosp Discharge Date ____/____/____ SNF Discharge Date ____/____/____

PROTOCOL INFORMATION

CPM Type: ❑ Knee ❑ Shoulder ❑ Wrist ❑ Elbow ❑ Hand ❑ Ankle ❑ Other _____

Beginning ROM _____ Increase ROM _____

Frequency Hrs/Day _____ ROM Goal _____

Procedure _____

❑ Lft ❑ Rt ❑ Bilateral ❑ Pre-Op Set-up

ORDER INFORMATION – ITEM 1

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

ORDER INFORMATION – ITEM 2

MANUFACTURER	OTI PART #	QTY.	PRICE EA.

COMMENTS:

_____

❑ *Visa* ❑ *MC* ❑ *AMEX* ❑ *Discover* ❑ *Check #* _____ *Amount* _____ *CC Exp Date* _____ *CVC #* _____

Card Holder _____ *CC #* _____ *Billing Zip Code* _____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

I give consent for treatment and request that payment of authorized Medicare and other benefits be made on my behalf to OTI for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits of compliance with current healthcare standards. I have been provided my Bill of Rights & Responsibilities, privacy notice, Supplier Standards, how to reach OTI 24/7, instruction on proper use, troubleshooting, potential hazards of equipment, community resource and home safety information, rights to refuse treatment.

❑ THESE HAVE BEEN VERIFIED:
- Proper Electrical Outlet
- Hand Controller Accessible
- Patient or caregiver has demonstrated competency in using the device
- Patient Comfortable in Device
- Switches Operable
- Cord(s) Unobstructed
- Device Working in Home
- Proper Patient Kit Application
- Secure Device Placement

Person Taught if other than Patient: _____

Comments:

Patient or Authorized Representative Signature _____ Date _____

Relationship to Patient / Reason for Signing _____

REP SIGNATURE	DELIVERED BY	PURCHASE/ RENTAL DATE	FACILITY CODE

White – OTI Copy Pink – Patient Copy

MEDVANTAGE

PATIENT DIRECT AGREEMENT
DVT PREVENTION SYSTEM

PH: (888) 412-8087 • Fax: (888) 522-0355
2134 S Richards Street • Salt Lake City, UT 84115

PLEASE COMPLETE ALL ITEMS IN YELLOW

Letter of Medical Necessity / Assignment of Benefits

Items Provided to Patient by MedVantage: Intermittent Pneumatic Compression Device and All Accessories

Please Apply
Patient ID Sticker
Here

Please Apply
SCD or DME Product Sticker or
Take-Home System Bar Code Sticker Here.

❑ *AT-HOME DVT Prevention System*

1.) Proof Of Delivery, Assignment of Benefits (AOB) and Authorization to Release Information:

I understand that signing this form acknowledges the items indicated above were delivered to me. I understand that signing this form authorizes MedVantage and/or billing affiliates (BA) to submit claims directly on my behalf to my insurance carrier(s) or other health or medical plans. I also understand that signing this form assigns to MedVantage (BA) my right to payment of any and all healthcare or medical benefits for the items described above. This means MedVantage (BA) will receive direct payment for these items. I understand that signing this form authorizes MedVantage (BA) to acquire from the surgery center, and to release to my insurance carrier(s) and any other of my health or medical plans, any information necessary to process this or a related medical claim. I agree MedVantage (BA) may contact me for any additional information necessary to process this claim. I understand that after my surgery I will receive an Explanation of Benefits (EOB) document from my health insurance company which explains how the insurance company processed a claim for products / services by MedVantage (BA). Further, I understand that the EOB is not a bill or invoice, and I have read and understand the information on the back of this form. I agree should I have questions regarding the applicable EOB that I am to call MedVantage (BA) and not the surgery center or physician for information. If I receive a check from my insurance carrier for this service, I agree to endorse and forward on to MedVantage or its designated affiliate at 2134 S Richards St, Salt Lake City, UT 84115.

X _____ _____

Signature of Patient / Responsible Patient Representative — Date

1 Point Risk Factors

- ❑ Age 41-60 years
- ❑ Minor Surgery planned
- ❑ History of prior Major Surgery
- ❑ Varicose Veins
- ❑ History of inflammatory bowel disease
- ❑ Swollen legs (current)
- ❑ Obesity (BMI > 25)
- ❑ Acute Myocardial Infarction (<1 month)
- ❑ Congestive Heart Failure (< 1 month)
- ❑ Sepsis (<1 month)
- ❑ Serious lung disease, including Pneumonia (< 1 month)
- ❑ Abnormal Pulmonary Function (COPD)
- ❑ Medical patient currently at bed rest
- ❑ Leg Plaster Cast or Brace
- ❑ Use of Tourniquet
- ❑ General Anesthesia (>30 minutes)
- ❑ Oral Contraceptive or Hormone Replacement Therapy
- ❑ Pregnancy or Postpartum (< 1 month)
- ❑ History of unexplained stillborn infant, recurrent spontaneous abortion (=3), premature birth with toxemia or growth-restricted infant

2 Point Risk Factors

- ❑ Age 61-74 years
- ❑ Major Surgery (> 45 minutes)
- ❑ Arthroscopic Surgery
- ❑ Laparoscopic Surgery (> 45 minutes)
- ❑ Previous Malignancy
- ❑ Central Venous Access
- ❑ Morbid Obesity (BMI > 40)

3 Point Risk Factors

- ❑ Age 75 years and over
- ❑ Major Surgery lasting 2-3 hours
- ❑ BMI > 50 (Venous Stasis Syndrome)
- ❑ History of SVT, DVT/PE
- ❑ Family History of DVT/PE
- ❑ Present Cancer or Chemotherapy
- ❑ Positive Factor V Leiden
- ❑ Positive Prothrombin 20210A
- ❑ Elevated Serum Homocysteine
- ❑ Positive Lupus Anticoagulant
- ❑ Elevated Anticardiolipin Antibodies
- ❑ Heparin-induced Thrombocytopenia (HIT)
- ❑ Other Thrombophilia

5 Point Risk Factors

- ❑ Elective Major Lower Extremity Arthroplasty
- ❑ Hip, Pelvis or Fracture (< 1 month)
- ❑ Stroke (< 1 month)
- ❑ Multiple Trauma
- ❑ Acute Spinal Cord Injury (Paralysis) (< 1 month)
- ❑ Major Surgery lasting over 3 hours

Surgical Risk Factors

- ❑ Revision Surgery
- ❑ Extensive Surgical Dissection
- ❑ Previous Major Bleeding
- ❑ Difficult-to-Control Bleeding During Current Operative Procedure

TOTAL RISK FACTOR SCORE: ➔ ☐

☐ **High Risk: 3+ Points**

☐ **Moderate Risk: 2 Points**

Length of Need: _____ (Unit)

Due to this patient's risk for developing deep vein thrombosis, I am prescribing mechanical DVT prophylaxis because of the following:

☐ My patient has been prescribed antibiotics, NSAIDs or other medication documented by pharmaceutical manufacturers to have contraindications with anticoagulants, causing major interactions including but not limited to allergic skin reactions and excess bleeding

☐ My patient has been prescribed mechanical prophylaxis AND anticoagulants because of their level of risk.
American Journal of Medicine, Feb. 2012, Allergy,2006 Dec; 61 (12) 1432-40, Cochrane Database of Systematic Reviews 2008, Issue 4, Epocrates.com

Please Write ICD-10 Codes Here: X_____ X_____ X_____ X_____

2.) Letter of Medical Necessity / Physician Order

Deep Vein Thrombosis (DVT) is a significant risk factor for patients undergoing surgery and immobilized patients. Prevention of DVT is more effective than treatment and an important aspect of patient care before, during and after surgery. I have assessed this patient's risk of developing DVT due to age, type of surgery, patient and family medical history, and other documented factors that may increase the risk of DVT. My assessment indicates the use of mechanical thromboprophylaxis by pneumatic compression device and segmental gradient pressure pneumatic appliances. It is my opinion this is medically necessary and reasonable in accordance with accepted standards of practice and appropriate treatment of this patient.

X _____ _____ _____

Physician Signature *(OR ATTACH COPY OF SIGNED PHYSICIAN ORDER). Please do not stamp* — Printed Name / NPI# — Date

Top Copy: MedVantage — Second Copy: Surgery Center — Bottom Copy: Patient