

DME INFORMATION FORM

CMS-10125 — EXTERNAL INFUSION PUMPS

DME 09.03

Certification Type/Date: INITIAL ___/___/___ **REVISED** ___/___/___ **RECERTIFICATION** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and Medicare ID (____) ____ - _____ Medicare ID _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI # (____) ____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	SUPPLY ITEM/SERVICE PROCEDURE CODE(S): _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)	
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> _____ _____ _____	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (____) ____ - _____ UPIN or NPI # _____	
ANSWERS		ANSWER QUESTIONS 1-4 FOR EXTERNAL INFUSION PUMP.	
SUPPLY ITEM/SERVICE PROCEDURE CODE(S): a) _____ b) _____ c) _____		1. Provide the Supply Item/Service Procedure code(s) for the drug(s) that requires the use of the pump.	
a) _____ b) _____ c) _____		2. If a NOC (not otherwise classified) Supply Item/Service Procedure code is listed in question 1, print name of drug.	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		3. Check number for route of administration? 1 – Intravenous 2 – Subcutaneous 3 – Epidural 4 – Other	
<input type="checkbox"/> 1 <input type="checkbox"/> 2		4. Check number for method of administration? 1 – Continuous 2 – Intermittent	

Supplier Attestation and Signature/Date

I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

SUPPLIER SIGNATURE _____ DATE ___/___/___

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR EXTERNAL INFUSION PUMPS (CMS-10125)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
SUPPLY ITEM/SERVICE PROCEDURE CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

Date of Release: _____

Expected Date of Return: _____

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:
 - a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR
 - b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR
 - c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____

Received by: _____ Date: _____ Time: _____

Signature of person returning unused medications: _____

Staff signature of count on return: _____ Date: _____ Time: _____