Device trial request/funding packet.

Introduction

Thank you for including Lincare AAC® for your device trial. We are excited to partner with you and will do everything in our power to make the process as smooth as as possible. In order to facilitate this, please complete this packet accurately and completely, with all necessary documentation included. Missing, illegible, or incomplete information will cause processing delays. Following are some basic instructions on key pieces of the funding packet as well as a checklist to guide you on your journey. If you have any questions or need assistance, please reach out to us using the contact information on the next page.

The device trial request is the first step in the process. After your trial is successful, you can submit pages 9 through 23, which is the remaining information and paperwork necessary to request a device from your funding source.

How to fill out this form

Please complete the information within this packet accurately and fully, with all necessary documentation included. This packet may be filled out in one of two ways:

Printed: Print all pages, fill out the packet, sign it, then either email or fax the packet along with the required documentation. (Submission instructions on next page.)

PDF form: This packet can be filled out on a computer or tablet (such as an iPad). You must use a program that supports forms. Adobe Acrobat Reader is a free PDF program that is available for all operating systems and is the only program confirmed to work with these forms. Other PDF apps may not be compatible. If you have any questions on compatibility, please contact us.

Signature instructions for PDF forms

After completing this packet, print the entire packet, sign the appropriate forms, then rescan them for submission, unless faxing the paperwork.

Submission instructions

Email all required paperwork in one email to **NHCOrders@lincare.com.**
Fax all required paperwork together to **928.556.0709.**

Once the packet is received and verified, the funding request will be processed.

While Lincare AAC® maintains a secure data environment for electronic information including emails, we cannot guarantee the security of any information, including HIPAA protected or personal information, transmitted via a third party program for email (such as Google, AOL, AT&T, Verizon and others).

Support and contact information

The Lincare AAC team is here to support you in any way we can. Please contact us with any questions.
Email: devicetrial@lincareaac.com
Phone: 877.893.5305 (Monday - Friday, 8 am to 4:30 pm AZ MST)
Online: lincareaac.com

Device trial request checklist.

Device trial request form:

☐ Completed

☐ Attached

Device trial selection form:

☐ Completed

☐ Attached

Disclosure consent form:

☐ Completed

☐ Attached

Equipment loan agreement:

☐ Completed

☐ Attached

Copies of all insurance cards:

☐ Attached (Clear copies of the front and back of all cards)

Power of Attorney paperwork:

☐ Attached (Required if Power of Attorney is signing)

Device trial request form.

Section 1: Client information

Name (first and last): _____ Date of birth: _____

Preferred pronouns (optional): _____ Customer ID (internal use only): _____

Legally responsible/Contact person (if applicable)

Name: _____ Relationship to client: _____

Contact email address: _____

Primary contact phone number type: ☐ Home/office ☐ Mobile

Phone number: _____ Extension: _____

Secondary contact phone number type: ☐ Home/office ☐ Mobile

Secondary phone number: _____ Extension: _____

Residence address: _____

City: _____ State: _____ Zip: _____

☐ Shipping address is the same as the residence address. We cannot ship to a PO box, and Medicare-funded devices must be shipped to the patient's residence address. (Skip to "Place of Residence".)

Shipping address: _____

City: _____ State: _____ Zip: _____

Place of residence:

☐ Home ☐ Custodial care facility ☐ Assisted living facility ☐ Group home

☐ Intermediate care facilities for individuals with intellectual disabilities ☐ Skilled nursing facility ☐ Hospice

☐ Other: _____

Do you own, or have you previously owned, a communication device? ☐ Yes ☐ No

Section 2: Client diagnosis information (Include ICD-10 codes)

Medical diagnosis: _____ Date of onset: _____

Communication diagnosis: _____ Date of onset: _____

Is diagnosis the result of an accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: _____

Section 3: Speech-language pathologist information

Name (first and last): _____ Email: _____

Facility name: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____

State and license number: _____ ASHA number: _____

Section 4: Insurance information

Check and fill out only applicable sections. Fill out address only if different from client.

☐ Medicare ID number: _____ Medicare managed care? ☐ Yes ☐ No

☐ Medicaid ID number: _____ Medicaid managed care? ☐ Yes ☐ No

Name of managed care organization: _____

☐ Primary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

☐ Secondary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Trial device selection sheet.

Expression Series device

☐ Expression Micro ☐ Expression Mini ☐ Expression Classic ☐ Expression Supreme

Eye gaze systems

☐ Contact the evaluating speech-language pathologist to identify a trial device.

Preferred method (all that apply): ☐ Email ☐ Primary phone ☐ Secondary phone

Communication apps requested

Please list all apps requested for the trial period.

_____

_____

_____

_____

Mount/accessories

☐ Include a table mount for the trial device.

☐ Please contact the SLP to coordinate any requested accessories such as buttons or switches.

Preferred method (all that apply): ☐ Email ☐ Primary phone ☐ Secondary phone

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

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Disclosure consent form.

Customer ID (internal use only): _____

Patient name: _____ Patient DOB: _____

This form will be retained in your medical record.

In accordance with the HIPAA Privacy Regulations, applicable state laws, and our Notice of Privacy Practices, the Company is required to maintain the privacy of your protected health information.

In order for us to better protect your privacy, your health information and account information for medical treatment, will be discussed with those you choose to receive such information.

My health and account information may be used by the person(s) I authorize to receive this information for medical treatment, billing or claims payment, or other purposes as I may direct. I hereby authorize the following individual(s) to receive verbal and/or handwritten communications from the Company that may include health and/or account information about me:

Individual's name: _____Relationship to patient: _____

Individual's name: _____Relationship to patient: _____

I authorize the Company to leave voice messages concerning my heath information (i.e., test results, appointments/visits, etc.) at the following number: _____

This authorization shall be in force and effect until (check one):

☐ My services are concluded and billing is resolved; or

☐ _____ (a specific date or event), at which time this authorization expires.

I understand I have the right to revoke this authorization, in writing, at any time. The extent of this authorization is as follows (check one):

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse); or

☐ I authorize the release of my complete health record with the exception of the following information (check all that you choose to exclude, if any):

- ☐ Mental health records ☐ Communicable diseases (including HIV and AIDS) ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This acknowledgment must be completed and signed by the patient. If the patient is unable to sign this consent form, the patient's Power of Attorney may complete and sign it.

Signature of patient or POA: _____

Printed name of patient or POA : _____ Date: _____

For office use only. I attempted to obtain written consent for disclosures of protected health information, but the consent could not be obtained because: ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment

☐ An emergency situation prevented us from obtaining the consent

☐ Other (please specify): _____

Equipment loan agreement.

This EQUIPMENT LOAN AGREEMENT ("Agreement") is made as of the date of the last signature below by and between RCS Management Corp d/b/a Lincare AAC ("Lincare AAC") and _____("Borrower"), having an address at _____.

Lincare AAC and Borrower may be referenced collectively in this Agreement as the "Parties" or each individually as a "Party."

1. **Equipment.** Subject to all terms and conditions of this Agreement, Lincare AAC will loan to Borrower the equipment specified on the attached Exhibit A (the "Equipment"). At the end of the Term, Borrower shall return the Equipment in its original condition, ordinary wear and tear excepted. The Equipment is to be used only for the permitted use below.

2. **Term and Termination.** The term ("Term") of this Agreement shall be for one hundred eight (180) days beginning on _____. The parties can extend the term for one more one hundred eighty (180) day period; but in no event will the term be longer than one (1) year unless specifically required by regulation. Either Party may terminate this Agreement at any time by giving 15 days' written notice to the other Party. In addition, Lincare AAC may terminate this Agreement immediately in the event of Borrower's failure to comply with any of the terms and conditions of this Agreement.

3. **Permitted Use.** The Equipment shall be used solely for the purpose of a trial device and is not be utilized for evaluation of a particular patient or provided as a permanent device to a particular patient. Borrower represents to Lincare AAC that Borrower and/or its personnel are appropriately licensed and qualified to perform such trials using the Equipment.

4. **Responsibility for Loss or Damage.** Borrower shall keep Equipment free and clear of all claims, liens, encumbrances and legal processes of every type whatsoever. Borrower shall not remove from the Equipment any stencils, plates, labels, marks, trademarks, or other indicia of ownership identifying Lincare AAC. Borrower is responsible for any loss or damage to the Equipment from the time Borrower takes possession of it until it is returned to the possession of Lincare AAC. Lincare AAC will charge Borrower the full value of the Equipment for any lost or damaged Equipment. Equipment shall be considered lost if not returned to Lincare AAC within thirty (30) days of the termination of this Agreement, and Borrower shall be charged the full value for the Equipment.

5. **Indemnification.** Lincare AAC makes no representation or warranty regarding the Equipment while in use by Borrower. Borrower accepts all risks to itself and to any third parties that may result or arise out of the possession or use of the Equipment and agrees to indemnify and save harmless Lincare AAC, its officers, agents, and employees from all loss, cost and expense arising out of any liability or claim of liability for damages to person or property arising out of its possession or use of the Equipment.

6. **Assignment.** This Agreement is personal, and Borrower shall not assign this Agreement, or any privileges granted hereunder without the prior written consent of Lincare AAC.

7. **Miscellaneous.** The interpretation and performance of this Agreement shall be governed by the laws of the State of Florida, without giving effect to its conflicts of law provisions. No amendment or modification of this Agreement or waiver of the terms or conditions hereof shall be binding upon any party unless approved in writing by an authorized representative of such party.

IN WITNESS WHEREOF, Lincare AAC and Borrower have executed this Agreement as of the date of the last signature below as indicated by the signatures of their authorized representatives.

Borrower:

Signature: _____

Printed name: _____

Relationship to client: _____

Date: _____

RCS Management Corp (internal use only):

Signature: _____

Printed name: _____

Title: _____

Date: _____

Printed name of the patient referenced in Pargraph #3: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

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Funding instructions.

Introduction

We are happy that your trial was a success and that you have identified a suitable device for your client. The remaining pages will guide you through the remainder of the process necessary to complete the funding request. Your client may keep the trial device until they receive their funded device so they can continue to learn and communicate during the funding process.

Apple ID requirements

Lincare AAC® may create an Apple ID to facilitate distribution of the prescribed communication apps. An agreement for usage terms of the Apple ID are included and must be signed in order to submit for funding.

Trusted phone number

Apple requires a “Trusted Phone Number” for their two-factor authentication security measure. This may be a home, office, or mobile phone number. Additionally, it should be a phone number you can access readily as it may used to verify the user’s authenticity. This is an Apple requirement and Lincare AAC has no control over it.

Important note: The following form will ask you to select which phone number you want as your trusted phone number and you must select one. You may receive a confirmation code on your trusted phone number prior to receiving your device. This is part of the setup process, and no action is required on your part; please disregard it.

Submission instructions

Email all required paperwork in one email to **NHCOrders@lincare.com.**
Fax all required paperwork together to **928.556.0709.**

Once the packet is received and verified, the funding request will be processed.

While Lincare AAC maintains a secure data environment for electronic information including emails, we cannot guarantee the security of any information, including HIPAA protected or personal information, transmitted via a third party program for email (such as Google, AOL, AT&T, Verizon and others).

Support and contact information

The Lincare AAC team is here to support you in any way we can. Please contact us with any questions.
Email: devicetrial@lincareaac.com
Phone: 877.893.5305 (Monday - Friday, 8 am to 4:30 pm AZ MST)
Online: lincareaac.com

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Post-trial funding request checklist.

Patient agreement and consent:

☐ Completed

☐ Attached

Lifetime Release/Assignment of Benefits/Payment Agreement:

☐ Completed

☐ Attached

Apple ID creation and usage policy:

☐ Completed

☐ Attached

Speech-generating device DME prescription (from this packet or physician's own prescription):

☐ Completed

☐ Attached

SLP evaluation (written using the SGD evaluation criteria included with this package):

☐ Attached

Copies of all insurance cards (clear copies of the front and back of all cards):

☐ Attached

Physician's face-to-face examination notes (if applicable):

☐ Attached

State Medicaid form (if applicable):

☐ Attached

Power of Attorney paperwork (required if Power of Attorney is signing):

☐ Attached

Post-trial funding request.

Section 1: Client/contact information

Name (first and last):_____ Date of birth:_____

Preferred pronouns (optional):_____ Customer ID (internal use only): _____

☐ **Client information has not changed from the trial request form. (Skip to section 2.)**

☐ **I have updated new or changed information below.**

Legally responsible/Contact person (if applicable)

Name: _____ Relationship to client: _____

Contact email address: _____

Primary contact phone number type: ☐ Home/office ☐ Mobile

Phone number: _____ Extension: _____

Secondary contact phone number type: ☐ Home/office ☐ Mobile

Secondary phone number: _____ Extension: _____

Trusted phone number: ☐ Use primary phone number ☐ Use secondary phone number

Residence address:_____

City:_____ State: _____ Zip: _____

☐ Shipping address is the same as the residence address. We cannot ship to a PO box. Medicare funded devices must be shipped to the patient's residence address. (Skip to "Place of Residence".)

Shipping address: _____

City:_____ State: _____ Zip: _____

Place of residence:

☐ Home ☐ Custodial care facility ☐ Assisted living facility ☐ Group home

☐ Intermediate care facilities for individuals with intellectual disabilities ☐ Skilled nursing facility ☐ Hospice

☐ Other: _____

Do you own, or have you previously owned, a communication device? ☐ Yes ☐ No

Section 2: Client diagnosis information (include ICD-10 codes)

☐ **Client diagnosis information has not changed. (Skip to section 3.)**

☐ **I have updated new or changed information below.**

Medical diagnosis: _____ Date of onset: _____

Communication diagnosis: _____ Date of onset: _____

Is diagnosis the result of an accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: _____

Section 3: Speech-language pathologist information

☐ **Speech-language pathologist information has not changed. (Skip to section 4.)**

☐ **I have updated new or changed information below.**

Name (first and last): _____ Email: _____

Facility name: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____

State and license number: _____ ASHA number: _____

Section 4: Insurance information

☐ **Insurance information has not changed. (Skip to section 5.)**

☐ **I have updated new or changed information below.**

Check and fill out only applicable sections. Fill out address only if different from client.

☐ Medicare ID number: _____ Medicare managed care? ☐ Yes ☐ No

☐ Medicaid ID number: _____ Medicaid managed care? ☐ Yes ☐ No

Name of managed-care organization: _____

☐ Primary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

☐ Secondary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address : _____

City: _____ State: _____ Zip: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Section 5: Treating physician information

Note: Section 5 is new. Please fill out completely.

Name (first and last): _____ Email: _____

Practice name: _____

Practice address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____ License number: _____

NPI number: _____ Medicaid provider number (If applicable): _____

Section 6: Equipment recommendations

Note: Section 6 is new. Please fill out completely.

_____

_____

_____

_____

_____

Section 7: Signature

Note: Section 7 is new. Please review and sign the following acknowledgement.

I verify that all information contained herein is true to the best of my knowledge. I understand that the information provided will be used for the purpose of obtaining funding and hereby give permission to release this information as requested by the funding sources listed.

I understand that I may be able to rent or purchase the equipment that has been prescribed by my physician. The rental duration will be according to the manufacturers' policies. I understand that if my insurance coverage requires a capped rental, I will be subject to the terms and conditions of the capped rental program.

Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Patient agreement and consent.

Account number: _____ Cell phone: _____

Patient name: _____ Email: _____

Address: _____ City/state/zip: _____

Type of equipment DME and supplies: **SPEECH-GENERATING DEVICE** Effective date: _____

Request for products, equipment, supplies, services
The undersigned, being the above-named Patient ("Patient"), and his/her guardian or representative payee, understands that by signing this Patient Agreement and Consent, the undersigned desires to rent or purchase, as or on behalf of Patient, certain medical equipment, products, supplies, prescription drugs, and/or associated services (collectively, to the extent applicable, the "Items") from SUPPLIER and its affiliates.

Acknowledgment of medical responsibility and informed consent
The undersigned, as or on behalf of Patient, understands that (1) Patient is under the supervision and control of an attending physician; (2) Patient's physician has prescribed the Items noted as part of Patient's treatment; (3) SUPPLIER's services do not include diagnostic, prescriptive, or other functions typically performed by physicians; and (4) Patient's physician is solely responsible for diagnosing and prescribing the Items or other therapies for Patient's condition and otherwise for controlling Patient's medical care. The undersigned, as or on behalf of Patient, has been informed by Patient's physician of the possible increased risks associated with in-home care, including possible delays in receiving treatment for life-threatening conditions as a result of being outside the hospital setting. The undersigned, as or on behalf of Patient, has discussed his/her concerns with Patient's physician and has had all associated questions answered to his/her satisfaction.

Acknowledgments of receipt and agreement to contact
The undersigned, as or on behalf of Patient, acknowledges receipt of a copy of each of the following: (1) the Medicare DMEPOS SUPPLIER Standards Statement; (2) SUPPLIER's Notice of Privacy Practices; (3) the Patient's Bill of Rights; and (4) the Patient Responsibilities. The undersigned, as or on behalf of Patient, agrees that SUPPLIER and its affiliates may contact Patient at the telephone number and/or email address specified hereon or as provided by the undersigned or Patient in the future.

Consent to release of health information for treatment, payment, and healthcare operations
The undersigned, as or on behalf of Patient, authorizes (1) Patient's insurer(s) and any other third-party payor(s) which provide Patient with coverage to disclose to SUPPLIER minimum necessary information to facilitate payment to SUPPLIER for items furnished Patient including, but not limited to, (A) payment made by such payor(s) to Patient, the undersigned, or to any other person or entity for Items provided by SUPPLIER to Patient; and (B) the scope and extent of Patient's coverage from time to time; (2) all medical personnel involved in Patient's treatment to disclose to SUPPLIER any and all information concerning Patient's medical history and condition as it may relate to the Items or treatment provided to Patient by SUPPLIER; and (3) any holder of medical information about Patient (including SUPPLIER) to release to the Centers for Medicare & Medicaid Services (or any successor agency) and its agents, to any of Patient's third-party payor(s) including, without limitation, Medicare, Medicaid, CHAMPUS, Tricare, or other public or private payors, and to SUPPLIER, any information needed (subject to "minimum necessary" requirements, as applicable) (A) to determine applicable benefits and qualification for reimbursement of Items furnished by SUPPLIER to Patient; (B) to process claims for Items provided by SUPPLIER to Patient; and/or (C) to conduct healthcare compliance activities (including pre- and post-payment audits) and quality assurance and utilization reviews. The undersigned, as or on behalf of Patient, hereby authorizes his/her healthcare providers and payors to rely on this "Consent to Release of Health Information," without the need for a separate release authorization, to release the specified information for treatment, payment, and healthcare operations purposes as contemplated herein. This consent shall not be effective to permit disclosures of information in cases where a HIPAA-compliant release authorization is required by law.

Agreement to pay
The undersigned agrees to pay for all Items provided by SUPPLIER to Patient. The monthly balance due will be that portion of SUPPLIER's applicable charges not paid by insurance or any other payor, including coinsurance, copayment and deductible amounts, as well as amounts due for non-covered Items provided to Patient by SUPPLIER. The undersigned agrees to pay the balance due in full upon receipt of an invoice from SUPPLIER. If prompt payment is not made, SUPPLIER may pursue its standard collection policy or other applicable remedies at SUPPLIER's sole discretion. If the undersigned fails to pay any amount due hereunder, he/she hereby grants SUPPLIER a lien and security interest under the Uniform Commercial Code in any personal property of the Patient to secure payment. If payment is more than 90 days past due, SUPPLIER may take all actions permitted by law to enforce the security interest and lien.

Credit check authorization
The undersigned, as or on behalf of Patient, authorizes SUPPLIER (1) to verify any financial or payment information disclosed by Patient or the undersigned and to perform a credit investigation for the purpose of extending credit for the purchase or rental of Items, and (2) to answer any questions from other creditors about Patient's or the undersigned's credit and account experience with SUPPLIER.

Assignment of benefits
The undersigned, as or on behalf of Patient, requests that payment of authorized benefits be made to SUPPLIER, and authorizes SUPPLIER to collect directly all public and private insurance coverage benefits due, for any Items furnished to Patient by SUPPLIER. In the event benefit payments due SUPPLIER are paid directly to Patient or the undersigned, the payee shall immediately, and without request from SUPPLIER, endorse and remit to SUPPLIER all such benefit payment checks. On assigned Medicare claims, SUPPLIER shall accept the applicable Medicare-allowable amount (including deductibles and copayment) in full for covered Items.

Miscellaneous
The undersigned certifies that the information provided to SUPPLIER by or on behalf of Patient under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is correct. Patient, if physically and mentally competent, must sign this Patient Agreement and Consent on his/her own behalf. If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This Patient Agreement and Consent is used in lieu of Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal health care program may, upon conviction, be subjected to fines and imprisonment under federal law. Penalties may also result from falsification or misrepresentation of other health insurance claims. A copy of this Patient Agreement and Consent may be used in place of the original.

The undersigned certifies that he/she (1) is the Patient, or is duly authorized to execute this Patient Agreement and Consent and accept its terms as or on behalf of Patient, and (2) has read the foregoing and understands and agrees to the terms hereof as or on behalf of Patient.

Area manager: **GINA SINGER** Telephone: **877.893.5305**

Patient, guardian, or authorized representative: _____ Authority to sign: _____ Date: _____

Authorized representative address: _____

Email: _____ Cell phone: _____

Consent to be contacted
Patient consents to receiving calls, emails, and texts from SUPPLIER and its affiliates related to the Patient's account, special offers from SUPPLIER and its affiliates, and advertising and telemarketing messages, which are made through automatic telephone dialing systems or an artificial or prerecorded voice at the telephone number and email address provided above. Standard message and data rates may apply. Signing this consent is NOT a condition of receiving services or equipment, or a condition of purchasing any property, goods, or services from SUPPLIER. The undersigned confirms that the telephone number and/or email address provided above are true and correct and belong to the Patient. I agree to notify the SUPPLIER in writing in the event my email address or telephone number changes.

Patient/authorized representative signature: _____ Date: _____

HIPAA marketing authorization
SUPPLIER is hereby authorized to use and disclose my contact information and order history to make marketing communications to me about products or services that I might be interested in. This Authorization will expire 15 months following the last date SUPPLIER furnished products and/or services, or at any time you choose to revoke this Authorization by calling Lincare AAC at 623.259.3558 or 877.893.5305. SUPPLIER may not condition your receipt of services or equipment on whether you choose to sign this Authorization. Disclosures for this purpose will only be made to SUPPLIER's contracted printers/mailing houses, and not to manufacturer partners. I acknowledge that SUPPLIER may receive financial remuneration from an affiliate or manufacturer whose product or service is being marketed. By law, we are required to notify you that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and thus no longer protected by HIPAA.

Patient/authorized representative signature: _____ Date: _____

Patient's right and responsibilities.

Patient's bill of rights

SUPPLIER will function using the following guidelines while providing patient care. The Patient/Client has the right to:

1. Receive service without regard to race, creed, gender, age, handicap, sexual orientation, veteran status, or lifestyle.
2. Participate in decisions regarding his/her care.
3. Receive information in a manner in which he/she can understand and be able to give informed consent to the start of any procedure or treatment.
4. Be provided with information concerning those aspects of his/her condition related to the care provided by SUPPLIER or other agencies contracted by SUPPLIER.
5. Be informed of any responsibilities he/she may have in the care process.
6. Have care provided by qualified personnel who are knowledgeable to perform procedures at the level of care required.
7. Refuse treatment to the extent permitted by law and to be informed of the consequences of such action.
8. Be informed of the availability, upon request, of SUPPLIER policies and procedures.
9. Be informed, at admission, of the organization's charges and policies concerning payment for services.
10. Discuss problems and suggest changes regarding the services or staff without fear of discrimination.
11. Privacy concerning his/her records.
12. Expect and receive care in a timely manner, appropriate to his/her needs.
13. Choose his/her home care provider.
14. Formulate advance medical directives, which are legal documents that allow him/her to give direction for his/her future medical care.
15. Be free from any mental or physical abuse, neglect, or exploitation of any kind by staff.
16. Have his/her property treated with respect.

Patient's responsibilities

As a home healthcare patient, you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies, infections, diseases, and other pertinent Items.
2. Assist in developing and maintaining a safe environment.
3. Inform SUPPLIER when you will not be able to keep a home care visit.
4. Participate in the development of and adherence to your home care plan of service/treatment.
5. Request further information concerning anything you do not understand.
6. Contact your physician whenever you notice any change in your condition.
7. Contact SUPPLIER whenever you have an equipment problem or if you change physicians.
8. Contact SUPPLIER whenever you have received a change in your home care prescription.
9. Contact SUPPLIER whenever you are to be hospitalized or receive services from a home health agency pursuant to a Medicare plan of care.
10. Give information regarding concerns and problems you have to SUPPLIER.
11. Ensure that the financial obligation for your equipment is fulfilled promptly.
12. Maintain and repair purchased equipment when equipment is no longer under warranty.
13. Follow equipment care procedures as outlined on Equipment Orientation Form.

SUPPLIER is a direct or indirect subsidiary of Lincare Holdings, Inc. Lincare Holdings, Inc. is owned by Linde North America Holdings Limited, a privately held company. If you feel that SUPPLIER has not respected your rights, we would ask that you please contact our area manager (shown on reverse side). It is the area manager's responsibility to review all formal complaints, and you will be entitled to a written response to your formal complaint. If feel that you have not received satisfactory resolution, you may contact CHAP at 800.656.9656, extension 242. I have reviewed and understand the Patient's Bill of Rights and my Patient/Client Responsibilities.

Lifetime release/Assignment of benefits/Payment agreement.

Customer ID (internal use only): _____

Client name: _____ Date of birth: _____

I authorize the release of any medical or other information necessary for determining benefits payable for equipment or services and processing claims by the Centers for Medicare and Medicaid Services, my insurance carrier, and any other medical/insurance entity. I understand that on occasion, funding or reimbursement barriers are encountered.

I authorize payment of my insurance benefits be made either to me or on my behalf to Lincare AAC® for any equipment or services provided to me. In certain circumstances, my insurance company may send a check for services provided by Lincare AAC directly to me. I agree to endorse and forward the check and "Explanation of Benefits" within five days of receipt to:

If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all equipment or services which have been provided by Lincare AAC.

I understand that I am financially responsible to Lincare AAC for any charges not covered by healthcare benefits. I agree to notify Lincare AAC of any changes in my healthcare insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill or balance of the bill as determined by Lincare AAC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received. This does not apply when Medicare determines the balance to be the contractor's obligation, or to Medicaid recipients.

I have read and understand the Lincare AAC 30-day return policy and the Patient Bill of Rights and Responsibilities (which includes the process to file a grievance or complaint with the Company, the Lincare AAC DMEPOS supplier standards, and the Lincare AAC notice of privacy practices).

Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

Apple ID creation and usage policy.

Customer ID (internal use only): _____

Client name: _____ Date of birth: _____

Lincare AAC® may create an Apple ID to facilitate distribution of authorized apps. All parties must agree to the following:

- The assigned Apple ID is only for the use of apps authorized by Lincare AAC.
- The user agrees to not utilize any iCloud features associated with the Apple ID including, but not limited to, email functionality or iCloud storage.
- The assigned Apple ID requires a trusted phone number which must be selected in the contact information section of the client information.

I have read, understand, and agree to the Lincare AAC Apple ID creation and usage policy.
Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

Speech-generating device DME prescription.

Order date: _____

Client information

Name (first and last): _____ Date of birth: _____

Insurance ID: _____

Street address: _____

City: _____ State: _____ Zip: _____

Clinical diagnosis

Medical diagnosis (Include ICD-10): _____

Communication diagnosis (Include ICD-10): _____

Prognosis with speech-generating device: ☐ Good ☐ Other: _____

Length of need: ☐ Lifetime ☐ Other: _____

Date of last practitioner visit: _____

Equipment prescribed

_____

_____

_____

_____

Physician information

I have reviewed a copy and agree with the speech-language pathologist's completed Augmentative Communication Evaluation for the above patient. The prescribed device and accessories are necessary to achieve the functional communication goals for this patient as noted in the SLP's treatment plan. I certify that a face-to-face examination for the patient's speech impairment has been documented in the patient record.

I do not have a financial relationship with, nor will I receive any other gain from, the manufacturer of the recommended device.

Practitioner's name: _____ Phone: _____

Practice address: _____ Fax: _____

City: _____ State: _____ Zip: _____

License number: _____ Issuing state: _____ NPI number: _____

Physician's signature: _____ Date: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Lincare AAC®
Augmentative. Alternative. Communication.

Signature

Please review and sign the following acknowledgement.

I verify that all information contained herein is true to the best of my knowledge. I understand that the information provided will be used for the purpose of obtaining funding and hereby give permission to release this information as requested by the funding sources listed.

I understand that I may be able to rent or purchase the equipment that has been prescribed by my physician. The rental duration will be according to the manufacturers' policies. I understand that if my insurance coverage requires a capped rental, I will be subject to the terms and conditions of the capped rental program.

Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

SGD evaluation criteria.

Per Centers for Medicare & Medicaid Services (CMS) regulations

A speech-generating device (SGD) (E2500 - E2510) is covered when all of the following criteria (1-7) are met:

1. Prior to the delivery of the SGD, the patient has had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP). The formal, written evaluation must include, at a minimum, the following elements:
   a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;
   b. An assessment of whether the individual's daily communication needs could be met using other natural modes of communication;
   c. A description of the functional communication goals expected to be achieved and treatment options;
   d. Rationale for selection of a specific device and any accessories;
   e. Demonstration that the patient possesses a treatment plan that includes a training schedule for the selected device;
   f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate;
   g. For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the patient of the upgrade compared to the initially provided SGD.
2. The patient's medical condition is one resulting in a severe expressive speech impairment.
3. The patient's speaking needs cannot be met using natural communication methods.
4. Other forms of treatment have been considered and ruled out.
5. The patient's speech impairment will benefit from the device ordered.
6. A copy of the SLP's written evaluation and recommendation have been forwarded to the patient's treating physician prior to ordering the device.
7. The SLP performing the patient evaluation may not be an employee of or have a financial relationship with the supplier of the SGD.

If one or more of the SGD coverage criteria 1-7 is not met, the SGD will be denied as not reasonable and necessary.

Codes E2500 – E2510 perform the same essential function; speech generation. Therefore, claims for more than one SGD will be denied as not reasonable and necessary.

Accessories (E2599) for E2500 – E2510 are covered if the basic coverage criteria (1-7) for the base device are met and the reasonable and necessary criteria for each accessory are clearly documented in the formal evaluation by the SLP.

Warranty and returns information.

Warranty

Lincare AAC® Lincare AAC® Expression Series devices come with a three-year limited warranty which begins on the date of device delivery to the user. Expression Series devices are protected with a three-year hardware warranty. Lincare AAC will honor all other manufacturer's warranties under applicable state law. Accessories (e.g., switches, keyguards, mounts) will follow the warranties of their respective manufacturers. Any replaced component will carry the balance of the warranty period. You will not be responsible for payment of repair or service for your equipment supplied by Lincare AAC during the warranty period. Guidelines for device replacement services are identified below:

a) Under this warranty, Lincare AAC will provide up to two (2) major repairs and up to two (2) minor repairs. An example of a major repair includes a device replacement or case replacement. A minor repair may include items like a replacement screen protector or strap.

b) If a case replacement is needed, the device must be in the original case when it is submitted for replacement. While under warranty, if it is deemed necessary that the user requires a different or specialized case (not a case that is one of our current case offerings), this must be pursued through the user's insurance provider(s).

c) If an unapproved Apple ID password is used on a device, the three-year warranty will be considered void.

d) Any and all warranty requests that require the speech generating device to be sent in for repair, must be sent with the device in it's original case.

If delivered item is deemed to be defective or does not meet your needs, Lincare AAC will accept the return or exchange of the item within 30 days of the device receipt. All products must be in new, unused condition to honor this service. If the product is not in this condition, restocking fees may apply. Some exceptions may apply for custom-build products, software, or special-ordered items that are non-refundable, as well as indicated products. Please contact Lincare AAC at 877.893.5305 for inquiries about a return or to obtain a return authorization number.

Obtaining warranty services

If a Lincare AAC device requires warranty service, please contact us at 877.893.5305. You will be provided with a device repair form to describe the problem, as well as a shipping label to ship the device back to Lincare AAC for repair. Once the device is repaired, the device will be shipped back to you. If warranty repairs to a device will be in excess of four (4) weeks, a short-term loaner device may be provided, based on availability.

Returns

Lincare AAC offers a 30-day money-back guarantee if our products do not meet your needs or expectations. Products must be in new and unused condition to honor this service; if not, restocking fees may apply. Some exceptions may exist for custom-built products, software, or special-ordered items are non-refundable, as well as indicated products.

Please contact Lincare AAC at 877.893.5305 for inquiries about a return, or to obtain a return authorization number (RT).

Medicare DMEPOS supplier standards.

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.