Device trial request packet instructions.

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 the “Post-Device Trial Funding Request” packet which will complete 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.

We strongly recommend that you send completed forms to us via a secure and encrypted email system. If you choose to email the form(s), please note that Lincare AAC cannot assure the security of your email transmission so there is a risk that protected health information (PHI) could be read, viewed or otherwise accessed by a third party. If you send via email, you will have assumed this risk to email the form(s) to us. There is no requirement to send the form(s) via email as they can be faxed.

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, 9 am - 4 pm 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 8.3 ☐ Expression 10.9 ☐ Expression 12.9

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): _____

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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.

2. **Term and Termination.** The term ("Term") of this Agreement shall be for thirty (30) days beginning on _____. The parties can extend the term for one more thirty (30) day period; but in no event will the term be longer than sixty (60) days unless specifically required by the third party payor of the particular patient. 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 evaluation of a particular patient, as named below, for use of the Equipment in such patient's speech therapy treatment. Borrower represents to Lincare AAC that Borrower and/or its personnel are appropriately licensed and qualified to perform such evaluation 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 sixty (60) days of the Effective Date, 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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