Post-trial funding request packet instructions.

Introduction

Congratulations! We are happy that your trial was a success and that you have identified a suitable device for your client. This packet 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.

This packet asks you to review and make any changes to previously supplied information, and there are several new sections to fill out as well. Please revise information as needed and provide the additional required documentation. Complete all information within this packet accurately and fully; missing, illegible, or incomplete information will cause processing delays. If you have any questions, please reach out to us using the contact information on the next page.

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.

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, fill out, and sign the forms in the packet. Then, either scan and email or fax the packet, along with the required documentation, using the submission instructions on the 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 programs may not be compatible. If you have any questions on compatibility, please contact us. After filling it out, 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: funding@lincareaac.com
Phone: 877.893.5305 (Monday - Friday, 9 am - 4 pm MST)
Online: lincareaac.com

Post-trial funding request checklist.

Post-trial funding request form:
☐ Completed
☐ Attached

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: 5 _____ 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: _____ Telephone: _____

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 _____. 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): _____

Patient name: _____ Patient DOB: _____

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.

Client information

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

Insurance ID: _____

Street address: _____

City: _____ State: _____ Zip: _____

Clinical information

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 physician visit (Must be within the last six (6) months for Medicare beneficiaries): _____

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.

Physician's name: _____ Phone: _____

Practice address: _____ Fax: _____

City: _____ State: _____ Zip: _____

State and license number: _____ NPI number: _____

Physician's signature: _____ Date: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Lincare AAC®
Augmentative. Alternative. Communication.

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

Expression Series devices have a three-year hardware warranty and Lincare AAC® will honor all manufacturers' warranties under applicable state law. If any item delivered to a rental beneficiary is substandard or unsuitable, Lincare AAC will accept the return or exchange of the item. You will NOT be responsible for payment of repair or service for your equipment supplied by Lincare AAC during the warranty period.

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).