Koffel Medical Supply, Inc.
Home Dialysis Patient Set-up Checklist

Facility Name: _____
Facility Address & Phone: _____

_____
(_____) _____ -_____

FACILITY SUPPORT SERVICE AGREEMENT

Koffel Medical Supply, Inc. will provide all necessary home kidney dialysis supplies and equipment as prescribed by your clinical staff. Koffel Medical Supply, Inc. will accept reimbursement for home dialysis supplies and equipment under assignment of benefits/agreement.

_____ agrees to furnish all medically necessary support, back-up and emergency dialysis services and all associated Support Services (i.e. Dietary, Social Services, Clinical Staff) required by CMS as defined in the Medicare Benefit Policy Manual Chapter 11 50.6

_____ _____
Authorized Signature of Dialysis Facility Representative Date

_____
Title of Authorized Dialysis Facility Representative

Koffel Medical
Home Dialysis Patient Management

Patient Name: _____

ASSIGNMENT OF BENEFITS

I have chosen Koffel Medical Supply, Inc. to furnish my home dialysis supplies and equipment prescribed by my attending physician. I understand my physician is responsible for prescribing all necessary dialysis supplies and equipment for my home dialysis treatments and, for the management of my medical condition.

I understand Koffel Medical Supply, Inc. is furnishing the dialysis supplies, equipment and/or services prescribed on my behalf. I hereby authorize Koffel Medical Supply, Inc. to request on my behalf, bill and collect directly all reimbursement due for the purchase of dialysis supplies and equipment supplied by Koffel Medical Supply, Inc. from public and private Payer Sources. In addition, I hereby authorize Koffel Medical Supply, Inc. to submit appeals, if necessary, to my payer source on my behalf. In the event any payments due to Koffel Medical Supply, Inc. are received by me, I hereby agree to endorse such payments over to and forward them directly to Koffel Medical Supply, Inc. This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois, without giving effect to any choice of law or conflict of law provision or rule (whether of the State of Illinois or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than that of the State of Illinois.

RELEASE OF INFORMATION

I authorize any holder of medical information about me to release to your company, the payer source and its agents any information needed for this or related claims. Further, I authorize the release of all information pertaining to health coverage benefits and status of claims submitted to the same referenced parties.

I certify that I have read the above information. I also certify that the undersigned is either the patient, or, is an authorized agent of the patient to execute and accept the above items.

_____ _____

Signature of Patient/Authorized Agent Date

_____

Relationship to Patient If Other Than Patient

Notice of Koffel Medical Supply, Inc. Privacy Policy

Koffel Medical Supply, Inc. will comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996, (Code 45 CFR 164-the Federal Privacy Regulations). The healthcare information you and/or your clinical care staff provide will only be used as necessary to process your home dialysis supply/equipment orders and applicable insurance claims. Safeguards have been implemented to maintain your medical record information confidential. Any questions concerning our policy can be directed to your reimbursement coordinator at (847) 816-8000

Koffel Medical Supply, Inc. / 1003 West Park Avenue / Libertyville, IL 60048 / 847-816-8000 / Fax 847-816-8606