



Referral Requirements

PLEASE INCLUDE THE FOLLOWING INFORMATION WHEN FAXING IN A REFERRAL:

- Fax coversheet (provided by Access MediQuip)
- Patient Demographics Form (you may use form provided by Access MediQuip or your own equivalent-include a copy of the front and back of insurance card)
- Certification/Order Form (provided by Access MediQuip-must be signed by physician)
- Patient Consent Form (use Access MediQuip form-must be signed by patient)
- Clinical information (clinical history and/or letter of medical necessity supporting implantable device)

Because of inconsistencies in carrier guidelines, we request that referrals be sent to us as soon as possible, but no later than five (5) business days prior to the date of the procedure.

However, because we understand urgent cases may arise, we will make every effort to accommodate special circumstances.



Fax Cover Sheet

To: Access MediQuip, L.L.C.	From:
Fax #: 713-985-4875	Fax #:
Toll Free: 877-985-4850	Phone # :
Patient:	
Date of Surgery:	
Facility:	
Procedure:	

*****Confidentiality Notice*****

The information in this fax and any attachments is confidential and is intended solely for the attention and use of the named addressee(s). If the reader of this message is not the intended recipient, or the employee, or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this communication is strictly prohibited. If you received this in error, please contact the sender immediately and destroy the material.



Patient Demographics

Procedure Information	
Procedure Scheduled Date:	
Ordering Physician:	
Procedure Location:	
Procedure:	
ICD-9 Diagnosis Code(s):	
Patient Information	
Patient Name:	
Patient Date of Birth:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Social Security Number:	
Patient Address:	
Patient Phone Number:	
Patient Employer:	
Patient Employer Address:	
Patient Employer Phone Number:	
Insurance Information	
Plan Type: Commercial <input type="checkbox"/> Workers Comp <input type="checkbox"/> Other <input type="checkbox"/>	
Does the patient have Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Primary <input type="checkbox"/> or Secondary <input type="checkbox"/>	
Insurance Company Name:	
Insurance Company Claims Address:	
Insurance Company Phone Number :	
Insured Name:	
Insured Date of Birth:	
Insured Social Security Number:	
Policy or Claim Number:	
Effective Date/Date of Injury:	
Group Number:	Adjustor Name:
Secondary Insurance:	
Secondary Company Phone Number:	Policy Number
Physician's Preauthorization Number:	



Access
MEDIQUIP
Patient Consent Form

Access MediQuip, L.L.C. (“Access”) is an outsourcing company providing implantable and specialty surgical devices to the healthcare industry. Access also issues claims for the devices directly to the patient’s insurance carrier.

This form is intended to grant authorization for Access to utilize medical information necessary for insurance authorization and reimbursement purposes, to define the financial responsibility for the implantable devices, and to confirm receipt of the Notice of Privacy Practices. Please contact the Billing Department at 1-877-985-4850 for additional assistance.

Definitions

- “I”, “me,” or “my” means the person who signs this form as the patient or the patient’s guardian or representative.
- “Patient” is the person stated below.

MEDICAL INFORMATION AUTHORIZATION: I hereby authorize **Access MediQuip, L.L.C. (“Access”)** to release any and all medical and/or billing records which have been created in connection with any evaluation, examination, diagnosis, prognosis and/or treatment rendered to the patient to any healthcare provider, insurance company, adjustor, case manager, employer, vendor of medical supplies and/or equipment, or attorney involved in the patient’s care/case.

AUTHORIZATION OF PAYMENT: I hereby assign to Access all rights to any payment made by any insurance carrier(s) or any other financially responsible party for items or services furnished by Access. I acknowledge that this document is a legally binding assignment and allows Access to collect payment from any insurance carrier or other financially responsible party providing coverage for items or services that Access furnishes to the patient. If the patient’s insurance carrier prohibits direct payment to Access, I instruct and direct the insurance carrier or other financially responsible party to make the check payable to me and mail the check to Access at the address indicated

on the claim. If I receive payment from the insurance carrier or other financially responsible party, I will endorse and deliver such payments to Access within five (5) days after I receive the payments. I understand that my failure to endorse and deliver such payments to Access may constitute insurance fraud and/or theft. I understand and agree that any amounts unpaid by insurance are my full responsibility. I also authorize the physician, treating facility and/or vendor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photo copy of this authorization shall be considered as valid as the original.

NOTICE OF PRIVACY: I have reviewed Access’ Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

SIGNATURE RELEASE: I further expressly agree and acknowledge that my signature on this document authorizes Access to submit claims for items or services that have been or will be furnished to the patient without obtaining my signature on each and every



claim to be submitted, and that I will be bound by this signature as though I had personally signed each individual claim.

Patient Name (printed)

Social Security Number

Patient Name/Guardian/Representative Signature

Date

Description of Personal Representative's Authority



Physician Profile

Physician Information:		
Physician Name:		
Medical License Number:	UPIN:	NPI:
Practice Name:		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone Number:	Fax Number:	Backline:
Office Contact Information:		
Primary Office Contact Person:		Title:
Direct Phone Number and Extension:		
Email:		
Does contact prefer to be contacted by phone or email?		
Secondary Office Contact Person:		Title:
Direct Phone Number and Extension:		
Email:		
Does contact prefer to be contacted by phone or email?		
Office Manager:		
Direct Phone Number and Extension:		
Email:		
Does contact prefer to be contacted by phone or email?		
If you have more than one physician in your practice please list them below, or use additional Physician Profile forms.		
Physician Name:		
Medical License Number:	UPIN:	NPI:
Physician Name:		
Medical License Number:	UPIN:	NPI:
What facilities will your physician(s) utilize Access MediQuip to supply the devices?		
Facility Name:		
Facility Phone Number:	Facility Contact Name:	
Facility Name:		
Facility Phone Number:	Facility Contact Name:	



Access
MEDIQUIP
Certification/Order Form

Today's Date:	Date/Time of Procedure:
Patient:	Patient Date of Birth:
Patient Address:	
Facility:	
Procedure:	ICD-9 Procedure Code:
Primary Dx:	ICD-9 Dx Code :
Additional Dx:	Additional ICD-9 Dx Code:

Neurostimulator Implant	
<input type="checkbox"/> Trial Stim	<input type="checkbox"/> Perm Stim <input type="checkbox"/> Perm Stim Revision
<input type="checkbox"/> Cervical	<input type="checkbox"/> Single Array
<input type="checkbox"/> Thoracic	<input type="checkbox"/> Dual Array
<input type="checkbox"/> Lumbar	
<input type="checkbox"/> Peripheral	
Manufacturer _____	

Pain Pump Implant	
<input type="checkbox"/> Trial Pump	
<input type="checkbox"/> Permanent Pump	
<input type="checkbox"/> Perm Pump Revision	
Manufacturer _____	

Joint Replacement Implant	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Total
<input type="checkbox"/> Knee	<input type="checkbox"/> Partial
<input type="checkbox"/> Hip	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Allograft
Manufacturer _____	

Spine Implant	
<input type="checkbox"/> Cervical	<input type="checkbox"/> Anterior
<input type="checkbox"/> Thoracic	<input type="checkbox"/> Posterior
<input type="checkbox"/> Lumbar	
# of Levels _____	<input type="checkbox"/> Allograft
Manufacturer _____	

Orthopedic Implant	
<input type="checkbox"/> Internal Fixation	<input type="checkbox"/> Allograft
<input type="checkbox"/> External Fixation	Site _____
Manufacturer _____	

Disc Decompression	
<input type="checkbox"/> Stryker DeKompressor	<input type="checkbox"/> Cervical
	<input type="checkbox"/> Thoracic/Lumbar
# of Levels _____	

Otologic Implant	
<input type="checkbox"/> BAHA	<input type="checkbox"/> Cochlear
Manufacturer _____	

Urologic Implant:	
<input type="checkbox"/> Penile Implant	<input type="checkbox"/> Testicular Prosthesis
Manufacturer _____	

Miscellaneous Equipment / Comments:

Medical Indication for Equipment (or attach LMN or H&P):

Access MediQuip to supply device for procedure
PHYSICIAN'S SIGNATURE REQUIRED

MD Name (printed)

MD Signature

Phone Number

UPIN

NPI