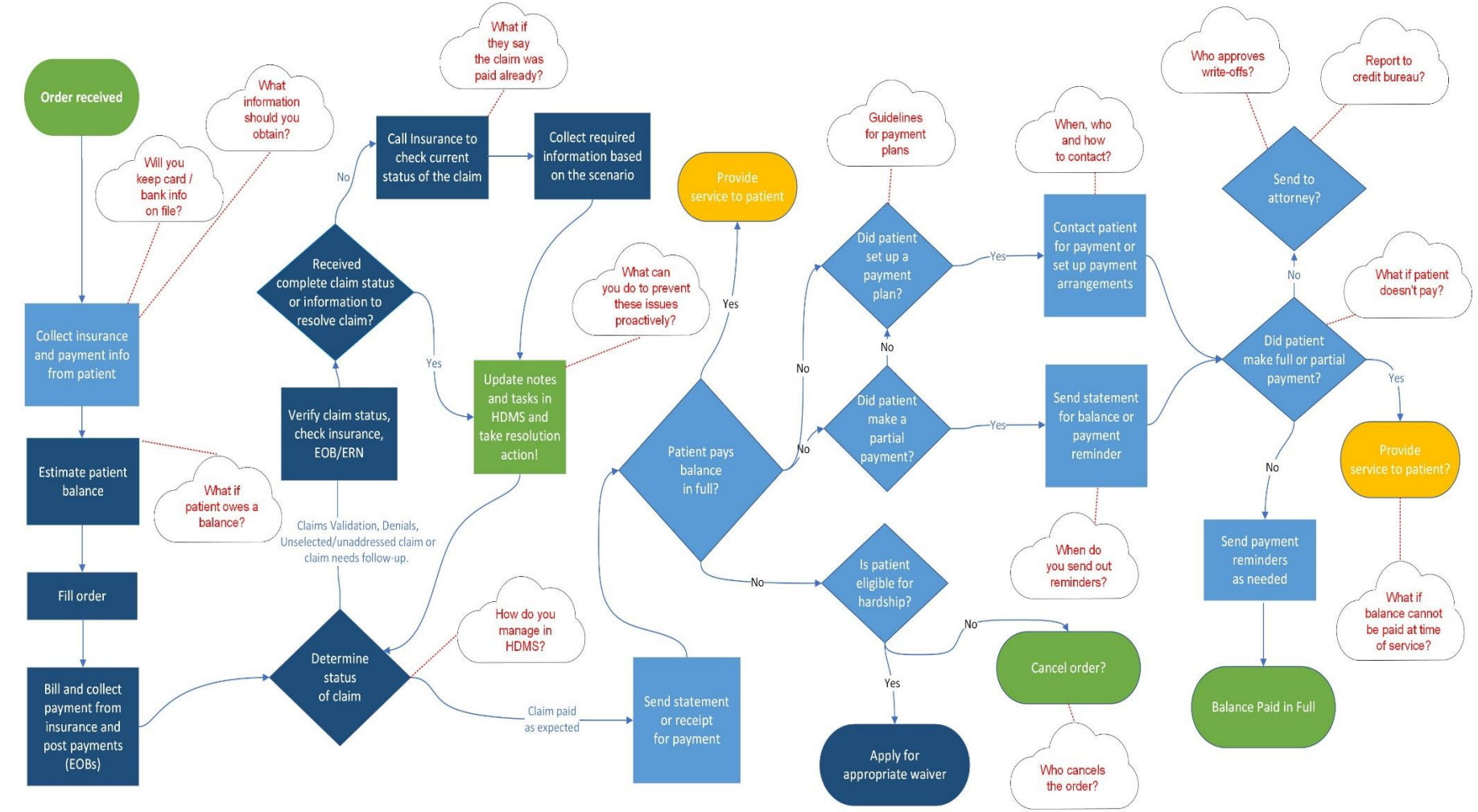
Impacting Collections at Intake

Resource Materials

HDMS
Healthcare Data Management System

allegiancegroup
IGNITING POSSIBILITIES

Patient Invoice Workflow



Note: This workflow is provided as part of edcational content published by Allegiance Group. It is best used in conjunction with articles ad content available on the Allegiance Group blog. This is a free resource provided to you.

Questions and information found on sample forms

Intake	
Patient information	**Physician Information**
Patient ID	Physician Name
Date	Phone number
Set Up by	Address
First Name	Fax Number
Last Name	City
Suffix	State
Street address	ZIP
City	UPIN#
State	NPI#
ZIP	DEA#
Social Security Number	Medical/State License #
Date of Birth	
Home Phone	
Cell Phone	
Authorization to text	
Email	
Authorization to email	
Alternate Contact First Name	
Alternate Contact Last Name	
Relationship to patient	
Alternate Contact Phone (Work/Home/Cell)	
Ship to Street address	
Ship to City	
Ship to State	
Ship to ZIP	
Ship to Phone number	
Social Security Number	
Approx Date at this address	
Credit Card type	
Credit Card number	
Expiration date	
Security code (3 or 4 digit code)	
Copay/Coverage	
Discussed copay with patient (Y/N)	

Rental/order	
Equipment order/ Shipping Ticket	**Rental Agreement Authorization/Consent**
Account number	Instructions (read front and back of form, signature indicates your approval)
Work Order number	Monthly Rental Charge
Work Order date	Anticipated Monthly Reimbursement
First Name	Patient Anticipated Monthly Responsibility
Last Name	Customary Purchase Charge
Suffix	Anticipated Reimbursement
Street address	Your Anticipated Responsibility
City	Payment method for ongoing payments
State	Credit Card on file for all rentals
ZIP	Will charge credit card if payment not received w/in 90 days from date of invoice
Telephone	Type of Credit Cards accepted
Delivery Date	Patient/Responsible Party signature
Delivery Method	Relationship of signer (if not patient)
Delivery Time	Date
Delivery Instructions	Email for Patient/Responsible Party
Internal coding	Why Patient is unable to sign
Plan of Service acknowledgement*	Emergency Contact Name
Intake CSR	Emergency Contact Phone number
Balance summary (charges for purchased/rented items, discounts, tax, total, payment, balance, copay balance)	Email for Emergency Contact
Patient/Responsible Party signature	Company Employee signature/ Title
Relationship of signer (if not patient)	Date
Date	
Email for Patient/Responsible Party	
Why Patient is unable to sign	
Emergency Contact Name	
Emergency Contact Phone number	
Email for Emergency Contact	
Company Employee signature/ Title	
Date	

Delivery

Delivery Ticket	Proof of Delivery
Account number	First Name
Work Order number	Last Name
Work Order date	Suffix
First Name	Street address
Last Name	City
Suffix	State
Street address	ZIP
City	Delivery Date and Time
State	Account number
ZIP	Insurance
Telephone	Delivery Method
Delivery Date	HIPAA authorization
Delivery Method	Supply policy (routinely purchased items for Medicare)
Delivery Time	Received Medicare Supplier Standards (if Medicare)
Delivery Instructions	Item details (Price, Unit of measure, number of cylinders, volume, quantity
Internal coding	Involvement in Plan of Service/Plan of care
Plan of Service acknowledgement*	Authorization to obtain medical information from any provider for proper
Intake CSR	Assignment of insurance benefits
Balance summary (charges for purchased/rented items, discounts, tax, total, payment, balance, copay balance)	Authorization to release medical info to insurance
Patient/Responsible Party signature	Accept financial responsibility; responsible for any charges not covered by insurance
Relationship of signer (if not patient)	Received, reviewed and understand Welcome packet*
Date	Balance summary (charges for purchased/rented items, discounts,
email for Patient/Responsible Party	Equipment clean and working
Why Patient is unable to sign	Refund policy (new and in original packaging)
Emergency Contact Name	If insurance notifies an overpayment, refund will be made timely using same
Emergency Contact Phone number	Items excluded for return, refund or credit (Oxygen contents, disposable supplies,
email for Emergency Contact	Rentals are property of company. Will be returned in good condition.
Company Employee signature/ Title	User will not try to repair equipment
Date	Signature of patient / authorized rep
	Relationship of signer (if not patient)
	Address of authorized representative
	Why patient was not able to sign
	Date received
	Associate confirmation

Payment Info

Patient Payment Information	**Insurance**
Account number	Medicare Number
Work Order number	Medicare Primary?
Date	Medicaid Number
First Name	State
Last Name	Issue Date
Suffix	Primary Insurance
Cardholder Name	Primary Insurance Phone
Credit Card type	ID Number
Credit Card number	Policy number/ Group number
Expiration date	Rx BIN#
Security code (3 or 4 digit code)	Rx PCN#
Cardholder Street address	Name of Insured
Cardholder City	
Cardholder State	Secondary Insurance
Cardholder ZIP	Secondary Insurance Phone
Cardholder email	Secondary Insurance ID Number
Amount of Payment	Policy number
Cardholder signature	Rx BIN#
Home phone	Rx PCN#
Cell phone	Secondary Insurance Name of Insured
Responsible Party information	Third Insurance (if needed)
First Name	
Last Name	**Insurance coverage:**
Suffix	Estimate insurance coverage
Street address	Are the needs of the patient within the coverage of their insurance plan?
City	Patient covered by insurance?
State	Information provided is correct
ZIP	Authorization to release medical info to insurance
Date of Birth	Assignment of Benefits
Home Phone	Conditions to change from Assigned to Non-assigned
Cell Phone	
Authorization to text	
Email	
Authorization to email	

Financial Policy
Instructions (read front and back of form, signature indicates your approval)
Financial information is an estimate
Estimated patient pay balance
Estimated monthly patient pay balance for rentals
Personal liability for payment due now and in the future under this contract
Amount paid today
Payment method
Name to use on check/how name will appear on credit card statement
Medicare hotline provided
Medicare may deny payment and a Advance Beneficiary Notice has been
Payment terms (30 days)
Will pay in full if no insurance payment w/in 60 days
Will pay in full if missing information not supplied w/in 45 days
Permission to contact any past or present employers re: insurance claim
Authorization for local Dept. of Social Services to release resource and income
Patient responsible for copays, deductibles or non-covered charges not covered by workman's comp
Patient responsible for copays, deductibles or non-covered charges not covered by
Will immediately transfer any payments from insurance
When patient will receive the first bill (after EOB)
Acknowledgement of billing and collection policy
Advanced directive or living will
Durable Power of Attorney
Signature of patient or representative
Relationship of signer (if not patient)
Date received
Why patient is unable to sign
Late fee? If so, amount of late fee

Other intake forms

Compliance
Consent for care
If receiving Drug Therapy, would like to consult with a pharmacist (Y/N)
Medical information authorization
Health Information Exchange
Rights regarding Protected Health Information
HIPAA authorization
Privacy Practices (PHI definition, uses, disclosures, complaint process)
Involved in Plan of Service/plan of care
Required documents to upload into the system
Proof of identification
Insurance documents
Medical records
Medical necessity
Other (please specify)
Welcome packet
Received packet, reviewed and understand contents
Packet includes patient's rights, patient responsibility, advanced directive information, state laws
Welcome email (list of potential content)
Introduction to you / your company
Short, relevant video with contextual information
Digital brochure containing information about your company
Content referencing you or your company (blog posts, articles, etc.)
Customer testimonials
FAQ
Send medical symptoms questionnaire (MSQ)
Lifestyle health questionnaire
Medical Symptoms Questionnaire

Patient's Rights
Be given information about your rights and responsibilities for receiving home care products and services
Receive a timely response from the home care company regarding physician's request for home care services
You will be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.
You will be informed, (both/either) orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible.
You will receive information about the scope of services that the organization will provide and specific limitations on those services
You will participate in the development and periodic revision of the plan of care.
You can refuse care or treatment after the consequences of refusing care or treatment are fully presented.
Accept or decline participation in research experimentation or educational training without punitive action being taken against you.
Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable.
You will have your property and person treated with respect, consideration, and recognition of client/ patient dignity and individuality
You will be able to identify visiting personnel members through proper identification.
You will be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property.
You will be able to voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal.
Company Name: Phone number
Accreditation Commission for Healthcare: 855-937-2242
Medicare Hotline: 1-800-MEDICARE
Telephone number for 24/7 registered pharmacist to answer questions
Your confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information will be maintained.
You will be advised on agency's policies and procedures regarding the disclosure of clinical records. Your records will only be shared with those you have given consent to review.
You will be able to choose a health care provider, including choosing an attending physician, if applicable
You will receive appropriate care without discrimination in accordance with physician orders, if applicable.
Be givien information regarding anticipated discharge from home health care services and/or transfer to a health care organization.
You will be informed of any financial benefits when referred to an organization.
You will be fully informed of your responsibilities.
You will have your property and person treated with respect, consideration, and recognition of your dignity and individuality
If client has been judged incompetent, the client's family or guardian my exercise the client's rights.

Patient's Responsibilities
Provide accurate and complete health information concerning your past illnesses, hospitalizations, medications, allergies and the pertinent items
Inform the company of any changes in insurances or hospitalizations.
Responsible to take care of any equipment provided to you.
Responsible for the payments of all co-pays and deductibles.
Responsible to adhere to your physician's prescription
Inform provider when you will not be home for a scheduled visit.
Request further information concerning anything you do not understand.
Give information regarding your concerns and problems to a Company staff member.
Inform company immediately when admitted to a hospital or nursing home and equipment is no longer required.
Notify company of change in insurance coverage.
Provide updated copy of Advance Directive, Durable Power of Attorney as appropriate.
Provide a safe environment for the company caregiver.

Advanced Directive

Plan of Service Acknowledgement
Equipment in good order and repair. Not responsible for damages while in user's possession
Equipment appropriate for patient's needs
Equipment set-up and adjusted for correct use
Equipment cleaning/maintenance reviewed
Won't release equipment to any other person, firm or corporation with the written consent
Fire/electrical safety reviewed
Information provided regarding routine and emergency services
Additional Comments:

Scope of Service
Service provided at home vs hospital or other medical institution
Any complication, injury or adverse result cannot be given immediate emergency medical attention
Can contact physician whenever I feel it is appropriate