AHS Member Demographics

AHS Member Demographics Date _____

Name: _____ Medicaid #: _____

DOB: _____ M/F: _____ SSN: _____

Height _____ Weight: _____

Placement Information

Agency: _____

Date: _____ Level of Care: _____

Prior DME: _____

Ins Company: _____

Point of Care Specialist: _____

Family Information

Name(s): _____

Primary Address: _____

_____

Language(s) spoken in the home: _____

Phone: Cell: _____ Home: _____

Email: _____

Mailing Address: (if different than physical address)

_____

_____

Service Agreement

Member Name: _____ Medicaid Number: _____

Service Standards & Expectations
Arrow Health Solutions is committed to the health and wellbeing of all the children and families that have selected us for their medical care. We strive to deliver all prescribed medical supplies and equipment in a timely and consistent manner to avoid supply shortages and undue stress on each family.

To assist us, we request any new prescriptions/orders from the primary care physician or specialist; requests for changes in size or product; and requests for changes in formula/nutrition **be submitted to our Point of Care Specialist at least 10 days prior to your monthly shipment**. In the event the information is received after this timeframe, we will ship out the new product as soon as the paperwork, authorizations, and insurance verification have been processed for the change order.

In the case of a medical emergency, Arrow Health Solutions will strive to work with the family and doctor to ensure the child receives the items needed to provide continuity of care.

Authorization/Consent to Provide Home Medical (Durable Medical) Equipment
I have been informed of the home medical (durable medical) equipment and supplies available to me and of the selection of providers from which I may choose. I authorize Arrow Health Solutions, LLC under the direction of the prescribing physician, to provide home medical equipment and supplies as prescribed by my physician.

Assignment of Benefits/Authorization of Payment
I hereby assign all benefits and payments on assigned claims to be made directly to Arrow Health Solutions, LLC for any home medical equipment and supplies furnished to me. I authorize Arrow Health Solutions, LLC to seek such benefits and payments on my behalf. It is understood that, as a courtesy, Arrow Health Solutions, LLC will bill Medicaid or other federally funded sources and other payers and insurer(s) providing coverage. I understand that I am responsible for providing all necessary insurance information beforehand. Any changes in my policy, plan, or insurance company must be reported to Arrow Health Solutions, LLC within 30 days of the event. I have been informed by Arrow Health Solutions, LLC of the medical necessity for the services prescribed by my physician.

Release of Information
I hereby request and authorize Arrow Health Solutions, LLC, the prescribing physician, hospital and any other holder of information relevant to my supplies, to release information upon request, to Arrow Health Solutions LLC, any payer source, physician, or any other medical personnel or agency involved in my equipment. I also authorize Arrow Health Solutions, LLC to review medical history for the purpose of providing home health care equipment and supplies.

Patient Handouts
I acknowledge that I have received a copy of the Patient Handbook, which contains Patient Rights and Responsibilities, Supplier Standards, and HIPAA Privacy Standards. I acknowledge that the information in the Patient Handbook has been explained to me and that I understand the information.

Grievance Reporting
I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my home care experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (346) 328-4800 or toll free (866) 328-4800 and ask to speak to the Arrow Health Solutions Operations Manager. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Vice President of Arrow Health Solutions, LLC. You can expect a written response within 7 working days of receipt.

Other Acknowledgements
I acknowledge I have received, read, and understand the policies outlined in the Arrow Health Solutions Disclosure Packet. I understand Arrow Health Solutions has the right to change the packet without notice. It is understood that future changes in policies and procedures will supersede or eliminate those found in this packet, and that patients and their responsible parties will be notified of such changes through normal communication channels.

Please initial and sign to acknowledge receipt of the following forms:

____ Patient Bill of Rights & Responsibilities
____ CMS Medicare DMEPOS Supplier Standards
____ Notice of Privacy Practices
____ Emergency Preparedness Recommendations

_____ _____
Signed Date

_____
Relationship to AHS Member

Beneficiary Change of Provider Form

The Medicaid Beneficiary has the right to choose their DME/Medical Supply Provider and the right to change providers.

Name of AHS Member: _____

Medicaid Number: _____ DOB: _____

Previous Provider(s): _____

Effective Date of Change: _____

Primary Care Physician: _____ Phone Number: _____

Primary Care Fax: _____

Specialist Name: _____ Phone Number: _____

Specialist Area: _____ Fax: _____

Specialist Name: _____ Phone Number: _____

Specialist Area: _____ Fax: _____

Specialist Name: _____ Phone Number: _____

Specialist Area: _____ Fax: _____

Specialist Name: _____ Phone Number: _____

Specialist Area: _____ Fax: _____

By signing below, I authorize Arrow Health Solutions to provide DME/Medical Supplies according to the effective date of change for the above stated Medicaid Beneficiary.

_____ _____

Signature Date

_____

Relationship to AHS Member

Office Use Only

The following HCPC codes are to be end-dated with the listed Previous Provider of DME supplies.

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

COMPLETE ALL SECTIONS, DATE AND SIGN

I. Authorization

I, _____, authorize Arrow Health Solutions to use and disclose the protected health information of, _____, described below to all medical sources including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

II. Effective Period

This authorization for release of information covers the period of healthcare from:

☐ _____ to _____

OR

☐ All past, present, and future periods.

III. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental health care, 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:

- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ other (please specify)_____

IV. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

V. This authorization shall be in force and effect until **TERMINATED** at which time this authorization expires.

VI. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

VII. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

VIII. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signed Date

_____

Relationship to AHS Member