PRISM
HOME MEDICAL SUPPLY SPECIALISTS

P. O. Box 476
Elkin, NC 28621
Phone: 1-888-244-6421
Fax: 1-800-975-6321
www.prism-medical.com

Patient Authorization for Services

MEDICARE PART A SERVICES

I understand that these supplies are not covered if I am utilizing my Part A benefit which includes, but is not limited to; Home Health Services, inpatient stays, or skilled nursing care provided in a skilled nursing facility (SNF). If I choose to accept these supplies while undergoing one of these episodes, as defined by CMS, I may be financially responsible for the cost of the supplied items.

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received and understand the statement of rights and responsibilities. The patient rights and responsibilities may also be found at www.prism-medical.com.

AUTHORIZATION FOR SERVICES

I authorize Prism to provide supplies and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment or medical supplies.

PATIENT HEALTH INFORMATION AND SUPPLIER STANDARDS

My signature below acknowledges I received a copy of the Notice of Privacy Practices and Supplier Standards. The Notice of Privacy Practices can also be found at www.prism-medical.com. The products and/or services provided to you by supplier, "Prism" are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained from the U.S. Government Printing Office website. Upon request we will furnish you a written copy of the standards. https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Standards%20Compliance~DMEPOS%20Supplier %20Standards~8WWJPE7260

ASSIGNMENT OF BENEFITS

I authorize payment directly to Prism of any benefits otherwise payable to examination or treatment of client. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law. Primary Insurance pays for 80%. Client is responsible for 20% of approved charges and any unpaid annual deductible. **I understand that Medicare or my primary insurance will only cover products deemed as "medically necessary" and payments made by Medicare is based on their regulations, utilization limits and fee schedules.**

EMERGENCY MANAGEMENT PLAN

My signature below acknowledges that I have established and understand the emergency plan. I have received Prism's brochure; I am informed of the nature and procedure to request additional supplies I may need; and I have participated in the planning of my care. There are no home visits appropriate for the care provided. The Prism Emergency Management Plan is located at www.prism- medical.com. You may also call to request the policy via mail.

RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Act, or under a policy of insurance is correct. I authorize the home care company or any other holder of medical or other information about the above named client, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above client; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the client or providing continuity of care; and to quality reviewers.

PRODUCT WARRANTY

All supplies distributed by Prism Medical Products, L.L.C. are guaranteed to be free from any defect. Any beneficiary that reports a defective product may return it within 10 business days to be replaced, free of charge. In addition, where applicable, directions for use and warranty information will be provided to beneficiaries for all products provided. Any remaining sealed supplies may be returned within 30 days for credit to the account. I have been instructed and understand the warranty coverage on the product(s) I have received.

Beneficiary's (Patient) Name	Date of Birth	Patient ID

Beneficiary's (Patient) or Caregiver Signature