InfuSystem®
SAFE. SMART. TRUSTED.℠

Contact InfuSystem to Learn More: 1-800-962-9656

Chemo Mouthpiece® Documentation Required to Order

Submit All Completed Information by Fax 1-248-565-4067 or Email CMPOrders@infusystem.com

- ☑ **Standard Written Order**
- ☑ **Assignment of Benefits**
- ☑ **Advanced Beneficiary Notice**
- ☑ **Patient Demographics, Including Insurance information**
- ☑ **Clinical Notes[1] – Include a signed progress note, visit summary and any relevant information such as diagnosis and prognosis. Please include any previously used methods to treat oral mucositis, what those methods were and the outcome.**

Chemo Mouthpiece Patient Assistance Program:
Patients can apply for Patient Assistance directly through Chemo Mouthpiece by calling **1-888-499-2122** or emailing **patientassistance@chemomouthpiece.com.**

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Any coding information provided: (i) is based on generally available third-party resources; (ii) does not constitute legal advice or a recommendation regarding clinical practice; (iii) may be obsolete; and (iv) may be inconsistent with the policies or requirements of any particular payer. Providers have the sole responsibility for determining medical necessity and the correct diagnosis code. You should consult your own advisors.

[1]The beneficiary's medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.
Source: cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426

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CHEMO MOUTHPIECE®

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Email: CMPOrders@infusystem.com

NPI#: 1790730596 NSC#: 1233120001

Standard Written Order

Facility Name:		Facility Account Number: *If Applicable*		
1 – STEP ONE: COMPLETE PATIENT AND INSURANCE INFORMATION				
First Name:	Last Name:	Middle Initial:	DOB: ___/___/___	Male ☐ Female ☐
Primary Address:		City:	State:	Zip:
Shipping Address:		City:	State:	Zip:
Cell Phone:	Alt. Phone:	Email:		
Emergency Contact Name:		Emergency Contact Phone:		
Primary Insurance:	Policy Holder:	Relationship to Policy Holder:		
Policy #:	Group #:	Phone:		
Secondary Insurance:	Policy Holder:	Relationship to Policy Holder:		
Policy #:	Group #:	Phone:		

2 – STEP TWO: DIAGNOSIS AND MEDICAL INFORMATION	
Primary Diagnosis and Description:	ICD-10:
Secondary Diagnosis and Description:	ICD-10:
☐ ICD-10 K12.31 Oral mucositis (ulcerative) due to antineoplastic therapy	
☐ ICD-10 K12.32 Oral mucositis (ulcerative) due to other drugs	
☐ ICD-10 K12.33 Oral mucositis (ulcerative) due to radiation	
☐ ICD-10 K12.39 Oral mucositis (ulcerative)	
☐ ICD-10 K13.29 Other disturbances of oral epithelium, including tongue	

3 – STEP THREE: PRESCRIPTION INFORMATION AND SIGNATURE		
Product: Chemo Mouthpiece	**Quantity:** 1 Kit	**Direction:** Use as directed by healthcare professional and follow provided device instructions.
Prescriber Signature: _____		
NPI #: _____		**Date:** ___/___/___

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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Assignment of Benefits

All Fields Must be Completed.

Insurance and Payment Responsibilities

I _____ request that payment of
(Print Patient Name)
authorized Medicare and/or private insurance benefits be made either to me or on my behalf to InfuSystem for any services furnished to me by InfuSystem.

I permit InfuSystem to release the information necessary to bill and collect payments directly from my health insurance plan for all services furnished by InfuSystem.

I agree InfuSystem may use an automated telephone dialing system and/or text messaging to contact me at any of the phone numbers I have provided for payment and clinical follow up purposes including email addresses.

I understand that I am responsible for charges not covered by my health insurance plan, such as co-insurance and deductible amounts.

Date of Birth: ____/____/____

Patient Signature: _____ **Today's Date:** ____/____/____

Facility Name: _____

InfuSystem Facility Account Number: _____

InfuSystem may use an automated telephone dialing system and/or text messaging to contact me at any of the phone numbers I have provided for payment and clinical follow up purposes. Message and data rates may apply. Message frequency may vary. For terms and conditions, visit www.infusystem.com/terms-conditions and for privacy, visit www.infusystem.com/privacy-hipaa. To receive help, text the word HELP to the number 36951. To stop receiving messages, text the word STOP to 36951.

IF PATIENT IS UNABLE TO SIGN, DESIGNEE SHOULD COMPLETE THE FOLLOWING INFORMATION

Designee Name (Printed): _____ Relationship to Patient: _____

Designee Signature: _____ Date: ____/____/____

Designee Address: _____

Reason Patient Cannot Sign (*Check One*): ☐ Physically Unable ☐ Mentally Unable ☐ Minor ☐ Other