POLICY
This policy describes procedures for ordering diabetic testing supplies for community residents with Medicare Part B coverage as their primary insurance to ensure their timely delivery and continuous supply.

PROCEDURES
Medicare requires orders to be mail-in only placed through an approved supplier. Ageia communities use Diabetic Experts of America a Division of Lincare Inc with Business Office Manager or Executive Director as persons authorized to and responsible for placing orders. To enroll a resident to receive mail-in diabetic testing supplies follow the steps below

- Fill out Patient Agreement, Disclosure and Order forms
- Fax the required paperwork to Diabetic Experts

After the supplier enters the resident information into their system a representative will be assigned to their case. The representative will contact the resident or Business Office Manager/Executive Director and resident’s physician to confirm the prescription and finalize supply order. The process can take up to two weeks.

A re-order card will be mailed to the facility every 90 days for reorders. Business Office Manager/Executive Director will be responsible for reordering diabetic testing supplies.

New residents should have a minimum of two weeks of testing supplies upon admission to ensure timely delivery of new order.

FORMS
Diabetic Experts of America Patient Agreement and Consent
Disclosure Consent Form
Fast Fax Order Form
Patient Name: ___________________________  Primary Insurance: ___________________________
Address: ________________________________  Policy #: ________________________________
City: ___________________  State: ___________  Zip: ___________________  Secondary Insurance: ___________________________
Date: ___________  Phone: ___________  DOB: ___________  □ Male  □ Female  Policy #: ________________________________

Diagnosis (ICD-10)

☐ E11.9  ☐ E10.9  ☐ Other: ________________________________

Supplies

*I prescribe the following diabetic supplies and have crossed out the items I am not prescribing.

E0607  Home blood glucose monitor (1/5 yr)
A4233  Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each (2/9 mo)
A4235  Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by Patient, each (2/9 mo)
A4253  Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256  Normal, low and high calibrator solution/chips (1/91 q)
A4258  Spring-powered device for lancet, each (1/6 mo)
A4259  Lancets, per box of 100
Other: ________________________________

Testing Frequency

Is the patient insulin treated? ☐ YES  ☐ NO

☐ Frequency: QD
100 lancets/3 mo and 100 test strips/3 mo

☐ Frequency: TID
300 lancets/3 mo and 300 test strips/3 mo

☐ Frequency: Other: ________________________________
_____ Lancets/___ mo and ___ test strips/___ mo

Medicare testing frequency guidelines are: 1x day non-insulin treated or 3x day insulin treated: If your patient's testing regimen exceeds the Medicare guidelines, please complete both A and B:

A. Has the patient been seen/evaluated in the last 6 months?
   ☐ YES  ☐ NO

B. I confirm that I have documented in the medical record the patient's actual times testing and the reason(s) for high testing frequency?
   ☐ YES  ☐ NO

Length of need: 99 -- Lifetime unless otherwise noted
Date of face-to-face visit prior to ordering DME

Fax completed form to: 888-810-4326
For additional information call us at: 888-810-4367

Diabetic Experts of America is a Division of Linstar, Inc.

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Disclosure Consent Form

This form will be retained in your medical record.

In accordance with the HIPAA Privacy Regulations, applicable state laws, and our Notice of Privacy Practices, the Company is required to maintain the privacy of your protected health information.

In order for us to better protect your privacy, your health information and account information will be discussed with those you choose to receive such information.

I hereby authorize the following individual(s) to receive verbal and/or written communications from Lincare that may include health and/or account information about me:

<table>
<thead>
<tr>
<th>Individual's Name</th>
<th>Relationship to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual's Name</td>
<td>Relationship to patient</td>
</tr>
</tbody>
</table>

(If additional names need to be included, please attach a separate sheet to this form, or write on the back)

I authorize Lincare to leave voicemail messages concerning my health information (i.e., test results, appointments/visits, etc.) at the following number:

Phone (___)

This acknowledgement must be completed and signed by the patient/beneficiary. If the patient is unable to sign this consent form then the patient's power of attorney may complete and sign it.

Signature of Patient (or Power of Attorney)  Date

For Office Use Only

I attempted to obtain written consent for disclosures of protected health information, but the consent could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining acknowledgement
☐ An emergency situation prevented us from obtaining the consent
☐ Other (Please specify)
Diabetic Experts of America
Patient Agreement and Consent

Account Number:

Patient Name:

Address-Street:

City:

State:

Zip:

Telephone:

Type of Equipment: HME and Supplies

REQUEST FOR PRODUCTS, EQUIPMENT, SUPPLIERS, SERVICES
The undersigned, being the above-named patient ("Patient") his/her guardian or
representative payee, understands that by signing this Patient Agreement and
Consent, the undersigned desires to rent or purchase, as or on behalf of Patient,
certain medical equipment, products, supplies, prescription drugs and/or associated
services (collectively, to the extent applicable, the "Items") from SUPPLIER and its
affiliates.

ACKNOWLEDGE OF
MEDICAL RESPONSIBILITY AND INFORMED CONSENT
The undersigned, as or on behalf of Patient, understands that (1) Patient is under
the supervision and control of his/her attending physician; (2) Patient’s physician has
prescribed the above noted as part of Patient's treatment; (3) SUPPLIER’s services do
not include diagnostic, prescriptive, or other functions typically performed by licensed
physicians; and (4) Patient’s physician is solely responsible for diagnosing and
prescribing the items or other therapies for Patient's condition and for otherwise
controlling Patient’s medical care. The undersigned, as or on behalf of Patient, has
been informed by Patient’s physician of the possible increased risks associated with
home care, including possible delays in receiving treatment for life threatening
conditions as a result of being outside the hospital setting. The undersigned, as or
on behalf of Patient, has discussed his/her concerns with Patient’s physician and has had
all associated questions answered to his/her satisfaction.

ACKNOWLEDGE OF RECEIPT AND
AGREEMENT TO CONTACT
The undersigned, as or on behalf of Patient, acknowledges receipt of a copy of each of
the following: (1) the Medicare Supplier Standards; (2) SUPPLIER’S Notice of Privacy
Practices; (3) the Patient’s Bill of Rights; (4) the Patient Responsibilities and (5)
information about Medicare covered items covered under warranty. The undersigned,
as or on behalf of Patient, agrees that SUPPLIER and its affiliates may contact Patient
at the telephone number specified herein.

CONSENT TO RELEASE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS
The undersigned, as or on behalf of Patient, authorizes (1) Patient’s insurer(s) and any
other third party payor(s) which provide Patient with coverage to disclose to SUPPLIER
minimum necessary information to facilitate payment to SUPPLIER for items furnished
Patient including, but not limited to (A) payment made by such payor(s) to Patient, the
undersigned or to any other person or entity for items provided by SUPPLIER to
Patient; and (B) the scope and extent of Patient’s coverage from time to time; (2) all
medical personnel involved in Patient’s treatment to disclose to SUPPLIER any and all
information concerning Patient’s medical history and condition as it may relate to the
items or treatment provided to Patient by SUPPLIER; and (3) any holder of medical
information about Patient (including SUPPLIER) to release to the Centers for Medicare &
Medicaid Services (or any successor agency) and its agents, to any of Patient’s third
party payers (including without limitation, Medicare, Medicaid, OCHAMPUS, TRICARE
or other public or private payers, and to SUPPLIER, any information needed (subject to

assurance or utilization reviews. The undersigned, as or on behalf of Patient, has
authorizes his/her health care providers and payors to rely on this “Consent to Right of
Health Information,” without the need for a separate release authorization, to rely
the specified information for treatment, payment and health care operations purpse
contemplated herein. This consent shall not be effective to permit disclosure information in cases where a HIPAA-compliant release authorization is required
pursuant to 45 CFR § 164.508.

AGREEMENT TO PAY
The undersigned agrees to pay for all items supplied by SUPPLIER to Patient.
monthly balance due will be that portion of SUPPLIER’s applicable charges not paid
by insurance or any other payor, including coinsurance, co-payment and deductible
amounts; as well as amounts due for non-covered items provided to Patient
SUPPLIER. The undersigned agrees to pay the balance due in full upon receipt of
invoice from SUPPLIER. If prompt payment is not made, SUPPLIER may pursue
standard collection policy or other applicable remedies at SUPPLIER’s sole discretion.

CREDIT CHECK AUTHORIZATION
The undersigned, as or on behalf of Patient, authorizes SUPPLIER (1) to verify
financial or payment information disclosed by Patient or the undersigned and perform
a credit investigation for the purpose of extending credit for the purchase rental of
items and (2) to answer any questions from other creditors about Patient’s
the undersigned’s credit and account experience with SUPPLIER.

ASSIGNMENT OF BENEFITS
The undersigned, as or on behalf of Patient, requests that payment of
benefits be made to SUPPLIER, and authorizes SUPPLIER to collect directly all public
and private insurance coverage benefits due, for any items furnished to Patient
SUPPLIER. In the event benefits payments due SUPPLIER are paid directly to
the undersigned, the payor shall immediately, and without request from SUPPLIER
endorse and remit to SUPPLIER all such benefit payment checks. On assign
Medicare claims, SUPPLIER agrees to accept the applicable Medicare allowable
amount (including deductibles and co-payments paid by the undersigned as or
benefit of Patient) as payment in full for covered items.

MISCELLANEOUS
The undersigned certifies that the information provided to SUPPLIER by or on behalf
Patient under Medicare (Title XVIII of the Social Security Act) and/or any other pub
private health insurance is correct. Patient, if physically and mentally competent,
shall sign this Patient Agreement and Consent on his/hers own behalf. If Patient
age, SUPPLIER may decline to perform services for the undersigned, as or on behalf of
Patient. Patient Agreement and Consent is used in lieu of Patient or his/hers representative’s signature on the "Request for Payment" HCFA-1500 and
other health insurance claims forms requiring signature and thus, is an extension
of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal health care program may, upon conviction, be punished to fines and imprisonmcnt under federal law. Penalties may also result for
representation of other health insurance claims. A copy of in
Patient Agreement and Consent may be used in place of the original.

The undersigned certifies that the (1) he/she is the Patient, or is duly authorized to execute this Patient Agreement and Consent and accept its
terms as or on behalf of Patient and (2) he/she has read the foregoing and understands and agrees to the terms hereof as or on behalf of
Patient.

Manager: Mike Pedersen

Telephone: 888-804-8615

PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE
RELATIONSHIP TO PATIENT / AUTHORITY TO SIGN

DATE

WITNESS

DATE