

Site Investigation for – **Durable Medical Equipment (DME) Suppliers**

Date Ordered: _____ Region/Director _____

Date of First Visit:	<input type="text"/>	Time:	<input type="text"/>
Date of Second Visit:	<input type="text"/>	Time:	<input type="text"/>

REASON FOR VISIT

- Application Reactivation/Re-Enrollment Appeal/Revocation
 Ad Hoc Request

Supplier Type:

Supplier Name:

Authorized Rep:

NPI:

Supplier Number:
(NSC/PTAN)

Address:

City:

Address 2:

State:

Telephone:

Zip Code:

Please obtain copies of the following documents if checked:

- | | | |
|---|---|--|
| <input type="checkbox"/> State Sales Tax Permit | <input type="checkbox"/> Business Liability Insurance | <input type="checkbox"/> Oxygen Permit |
| <input type="checkbox"/> DEA Certificate | <input type="checkbox"/> State DME Permit | <input type="checkbox"/> Other |
| <input type="checkbox"/> State Controlled Substance License | <input type="checkbox"/> Pharmacy License | |

If “Other”, explain:

INTERVIEW OF INDIVIDUALS PRESENT (Inspectors Should Complete Questions 1 – 27)

1) Individual Interviewed: Last Name: _____
First Name: _____

- Owner President Manager Administrator
 Other - Explain:

2. Y N Does the owner or any relatives own (or has previously owned) any additional locations other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.

If yes, please supply:

Owners Name: _____
Relationship: _____
Business Name: _____
Address: _____
City: _____
State: _____

3. The supplier should provide a listing of all management and owners, including name and title.
 Copy Attached

4. Y N Site Visit Completed? If unable to conduct site visit for any reason, please explain in the Additional Comments section at the end of this form.

FACILITY INFORMATION

5. Type of facility:

- | | | |
|---|--|--|
| <input type="radio"/> Storefront | <input type="radio"/> Office Suite-Mall | <input type="radio"/> Office Suite-Office Building |
| <input type="radio"/> Public Storage Facility | <input type="radio"/> Private Residence | <input type="radio"/> Warehouse Only |
| <input type="radio"/> Warehouse with Office | <input type="radio"/> P.O/Commercial Mailbox | |
| <input type="radio"/> Other. Please describe: | | |

a. What is the approximate size of the facility?

b. Were there signs of customer activity in the facility during the inspection? Y N

c. Is this facility normally visited by beneficiaries? Y N

6. Y N Is the facility handicapped accessible?

Photo

Attached If no, how does the supplier accommodate handicapped beneficiaries?

7. Y N Is there a sign with the supplier's business name posted on the facility?

○ Photo
Attached

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8. Y N Hours of operation posted? Please list hours of operation below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total Hours

9. Y N Does the supplier share office space with other DME suppliers or other businesses?

If "Yes", please list names of companies, owners and type of business (e.g., physician office):

a. Y N Does the co-located facility share office personnel?
If yes, describe.

b. Y N Does the co-located facility share services/equipment?
If yes, describe.

c. Y N Does the co-located facility share EIN or ownership?
If yes, describe.

d. Y N Does the co-located facility share specialty (provides same or similar types of services.) If yes, describe.

RECORDS & TELEPHONE

10. Y N Are the patient records maintained at this location?
- a) Y N Do these records include documentation of delivery, such as supplier delivery slips?
- b) Y N Do these records include supplier maintenance records?
- c) Y N Do these records include beneficiary communications, such as complaints or questions received from beneficiaries?

If "No" to any of the above, please explain:

11. Y N Do they have a business phone number (other than a cellular phone) for this location listed in a local telephone directory under the business name?

Confirmed by: White/yellow Pages Directory Assistance Internet Search

What is the business telephone number?

LICENSING/CERTIFICATION

12. Y N Does the supplier have valid occupational and business licenses applicable to their business?
 Copy Attached If "No", Explain: _____
13. Y N Are the supplier's business, customers, and employees covered by comprehensive liability insurance with the NSC listed as a Certificate Holder?
 Copy Attached
14. Y N Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items for sale? If yes, provide proof of employment and copies of licenses/certifications for the individual(s) providing this service?

- a) Y N Does the supplier fabricate or fit items for sale from its own inventory?

b) Y N Does the supplier contract with other companies for the purchase of items necessary to fill the order? If "Yes", identify the company:
Company Name _____
Street Address _____
City _____
State _____
Telephone # (____) _____

15. Y N Does the supplier provide or plan to provide diabetic footwear?
 Copy If yes, provide proof of employment and copies of licenses/certifications for the
Attached individuals this service?

16. Y N Does the supplier provide or plan to provide oxygen or oxygen related equipment?
Copy If yes, provide proof of employment or contract and copies of licenses/certifications
Attached for the individual(s) providing this service?

INVENTORY

17. Y N Does the supplier have inventory in stock?
 Photo
Attached Briefly provide description of inventory:

a) Y N Does the supplier provide products/services to customers other than Medicare beneficiaries?
Describe:

b) Y N Is all of the inventory stored on site?
If "No", please provide off site storage address:
Street Address _____
City _____
State _____

- c) Y N N/A
 Copy
Attached
- If supplier does not have a sufficient amount of inventory in stock, do they have a contract with another company to purchase DME supplies?
(Please attach a copy of the contract.)

If "Yes", identify the company:

Company Name _____
Street Address _____
City _____
State _____
Telephone # () _____

CONTACT WITH BENEFICIARY

18. Y N Is a current copy of the Supplier Standards provided to all Medicare patients?
 Y N If "No", was the supplier provided with a copy of the current Supplier Standards and advised of this regulatory requirement?
19. What methods does the supplier utilize to obtain beneficiary referrals and new customers?
Describe: _____
20. Y N Does the supplier furnish contact information to beneficiaries at the time of delivery,
 Copy e.g. an equipment sticker label listing the supplier's name and telephone number?
Attached
21. Y N Does the supplier have a written complaint procedure and log established?
 Copy If "Yes", attach a copy of their complaint policy and complaint log.
Attached
22. Y N Does the supplier accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries? If "No" explain the reasons why.

23. Y N Does the supplier maintain documentation showing that it has provided equipment
 Copy warranty information to beneficiaries, including how repairs and exchanges will be
Attached handled? If "Yes", attach a copy of an example.
24. Y N Does the supplier rent Durable Medical Equipment?

25. Y N N/A Does the supplier advise beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the Capped Rental Policy? If "Yes", attach a copy of company policy as an example. If "No" explain the reasons why.

26. Y N Does the supplier directly service and maintain DME items it rents to beneficiaries?

a) Y N If "No", do they have a service contract with another supplier?
 Copy Attached

b) If "Yes", provide name of company, phone number, and attach contract.

Company Name _____
Street Address _____
City _____
State _____
Telephone # () _____

27. Y N Does the supplier provide the beneficiary with written information and instructions on how to use and care for Medicare covered items safely and effectively? (This information may consist of brochures from the supplier or manufacturer's manuals. If "Yes", attach a copy. If "No" explain the reasons why.

Printed Name of Site Visit Inspector:

Date of Inspection:

Signature of Site Inspector

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is XXXX-XXXX. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn.: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ADDITIONAL COMMENTS

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