DEPARTMENT OF HEALTH AND HUMAN SERVICES Form Approved

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB No. 0938-1016

**MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM**

Name of DME Supplier – Provided by the CBIC

Type of DME – to be Provided by the CBIC

**INSTRUCTIONS:** Please rate the services you received from your DME supplier. Check the box that best describes your experience. If a question does not apply to you, please skip to the next question.

**N/A VERY POOR FAIR GOOD VERY**

1. **ARRANGING FOR EQUIPMENT** **POOR GOOD**

How would you rate your initial interaction with the DME **□ □ □ □ □ □**

supplier from which you recently received your DME?

**N/A VERY POOR FAIR GOOD VERY**

1. **TRAINING** **POOR GOOD**

How would you rate the training you, or the person who **□ □ □ □ □ □**

takes care of you, received from the DME supplier

regarding the DME you recently received?

**N/A VERY POOR FAIR GOOD VERY**

1. **DELIVERY OF EQUIPMENT** **POOR GOOD**

How would you rate your experience with the DME  **□ □ □ □ □ □**

supplier concerning delivery of the DME?

**N/A VERY POOR FAIR GOOD VERY**

1. **EQUIPMENT QUALITY** **POOR GOOD**

How would you rate the quality of the DME provided by the  **□ □ □ □ □ □**

DME supplier?

**N/A VERY POOR FAIR GOOD VERY**

1. **CUSTOMER SERVICE** **POOR GOOD**

How would you rate the customer service provided by  **□ □ □ □ □ □**

the DME supplier?

**N/A VERY POOR FAIR GOOD VERY**

1. **OVERALL COMPLAINT HANDLING** **POOR GOOD**

How would you rate the DME supplier’s overall **□ □ □ □ □ □**

complaint handling?