

## Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Date Ordered:

Date of First Visit:	<input style="width: 90%;" type="text"/>	Time:	<input style="width: 90%;" type="text"/>
Date of Second Visit:	<input style="width: 90%;" type="text"/>	Time:	<input style="width: 90%;" type="text"/>

### REASON FOR VISIT

- Application     
  Appeal     
  Ad Hoc Request     
  Revalidation     
  Reactivation

Supplier Type:

Supplier Name:

Authorized Rep:

Supplier Number:

National Provider Identifier (NPI):

Address:

City:

Address 2:

State:

Telephone:

Zip Code:

**Please obtain copies of the following documents if checked:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Business Liability Insurance | <input type="checkbox"/> Oxygen Permit | <input type="checkbox"/> Pharmacy License |
| <input type="checkbox"/> State DME Permit             | <input type="checkbox"/> Surety Bond   | <input type="checkbox"/> Other            |

If "Other", explain: \_\_\_\_\_

### FACILITY INFORMATION

1. Type of facility:

- Attach Photo   
  Storefront     
  Suite-Mall/Plaza     
  Suite-Office Building  
 Private Residence   
  Warehouse (Only)     
  Office-Warehouse attached  
 Other (please describe): \_\_\_\_\_

- a. What is the approximate size of the facility? \_\_\_\_\_
- b. Is access to facility restricted (gated community, call box, etc)?       Y  N
- c. Are there customers or signs of business activity during the inspection?       Y  N
- d. Is this facility normally visited by beneficiaries?       Y  N
- e. If a home based business, are all local zoning requirements met?       Y  N  N/A

2.  Y  N      Is the facility accessible to the disabled?
- Attach Photo      If no, how does the supplier accommodate disabled persons?
- \_\_\_\_\_

3.  Y  N      Is there a permanent, visible sign with the supplier's business name posted on the facility?
- Attach Photo

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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 0938-0749. 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, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244- 1850.

4.  Y  N Are hours of operation posted?  
 Attach Photo  
 Open 24/7 (Open 24 hours a day, 7 days a week) OR  
 By Appointment Only (no fixed days or hours) OR

Please list hours of operation below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total Hours:

5.  Y  N Was the site visit completed? If unable to conduct site visit for any reason (supplier not operational or inspection refused), please explain in the Additional Comments section at the end of this form.

<b>INTERVIEW OF INDIVIDUAL(S) PRESENT</b>
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6. Individual(s) Interviewed: Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Owner     President     Manager     Administrator  
 Other - Explain: \_\_\_\_\_  
 Additional Information: \_\_\_\_\_

7. The supplier must provide a list of all owners and management with day-to-day control, including name and title.  
 Attach Copy

8.  Y  N Does the supplier have other locations that service Medicare beneficiaries? If additional space is needed, please use the Additional Comments section at the end of this form.  
 If yes, please supply the following items:  
 Business Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_  
 PTAN: \_\_\_\_\_

9.  Y  N Does the owner or any relatives own(ed) any other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.  
 If yes, please supply the following items:  
 Owners Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Business Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_

10.  Y  N Does the supplier share office space with other DME suppliers or other medical businesses?  
 If "Yes", please supply the following items:  
 Business Name: \_\_\_\_\_  
 Type of business: \_\_\_\_\_  
 Owner(s): \_\_\_\_\_

Do the co-located businesses share any of the following items?

- a.  Y  N Entrances  
 b.  Y  N Office personnel/ownership  
 c.  Y  N EIN  
 d.  Y  N Telephone  
 e.  Y  N Inventory

If yes to any of the above, please describe and attach photos.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RECORDS & TELEPHONE**

11. Are the patient records maintained (check all that apply)  at this location?  
 at an off-site storage facility?  
 electronically?
- a)  Y  N Do these records include physician ordering/referral documentation?  
b)  Y  N Do these records include beneficiary communications, such as questions received from beneficiaries and progress notes?  
c)  Y  N Do these records include documentation of delivery?  
d)  Y  N Do these records include documentation of maintenance, repairs, or exchanges?  
e)  Y  N Do these records include proof the supplier provided equipment warranty?  
 Attach Copy
- f)  Y  N Do these records include proof the supplier advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the capped rental policy?  
 Attach Copy
- g)  Y  N Do these records include proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively?  
 Attach Copy
- If "No" to any of the above, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12.  Y  N Does the supplier have a written complaint policy/procedure established and document for logging complaints? If yes, please attach a copy of their complaint policy and complaint log.  
 Attach Copy
13.  Y  N Does the supplier have a business phone number (other than a cellular phone) listed in a local telephone directory under the business name?  
Please list the phone number: \_\_\_\_\_
- a) How was the phone number verified (check all that apply)?  
 White/Yellow Pages  Directory Assistance
- b) Was there telephone activity during the site inspection?

**LICENSING/CERTIFICATION**

14.  Y  N Are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with NSC as the certificate holder.)  
 Attach Copy If "No", Explain: \_\_\_\_\_
15.  Y  N Does the supplier have valid state and federal licenses applicable to their business?  
 Attach Copy If "No", Explain: \_\_\_\_\_
16.  Y  N Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items?  
 Attach Copy If yes, what are the name(s) and qualifications of those providing this service?  
\_\_\_\_\_  
\_\_\_\_\_
- a)  Y  N Does the supplier fabricate items onsite?
- b)  Y  N If no, does the supplier contract with other companies for the purchase of items necessary to fill orders? If yes, please identify the company:  
Company Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_

17.  Y  N Does the supplier provide diabetic footwear?  
 Attach Copy If yes, what are the name(s) and qualifications of those providing this service?  
\_\_\_\_\_  
\_\_\_\_\_

18.  Y  N Does the supplier provide oxygen or oxygen related equipment?  
 Attach Copy If yes, what are the name(s) and qualifications of those providing this service?  
\_\_\_\_\_  
\_\_\_\_\_

**INVENTORY**

19.  Y  N Does the supplier have inventory stored on site?  
 Attach Photo Briefly provide description of inventory present: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20.  Y  N Does the inventory present support the supplier's billing history?  
 N/A – No billing history

a) If “No”, please obtain invoices and/or contracts to verify the purchase of DME supplies.  
 N/A or  Attach Copy  
Vendor Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

b)  Y  N Does the supplier maintain an off-site storage facility?  
If yes, please provide:  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_

c)  Y  N Does the supplier accept other types of health insurance? If yes, please list:  
\_\_\_\_\_  
\_\_\_\_\_

21.  Y  N Does the supplier rent Durable Medical Equipment?

a)  Y  N If “Yes”, does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

b)  Y  N Do they have a service contract with another supplier?  
 Attach Copy If “Yes”, please identify the company:  
Company Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

If no to any of the above, please provide an explanation:  
\_\_\_\_\_  
\_\_\_\_\_

**CONTACT WITH BENEFICIARY**

22.  Y  N Is a copy of the current Supplier Standards provided to all Medicare patients?

23.  Y  N Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via telephone? If yes to third-party vendor, list company name(s). If no, please describe what methods the supplier uses to obtain new customers?  
Describe: \_\_\_\_\_

24.  Y  N      Does the supplier furnish contact information to beneficiaries at the time of delivery?  
 Attach Copy      Example: an equipment sticker label listing the supplier's name and telephone number
25.  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:

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**SIGNATURE AND DECLARATION**

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Printed Name of Site Visit Inspector

\_\_\_\_\_  
Date of Inspection

