Form Approved
OMB No. 0938-0749
Expires XX/XX

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

Date Ordered:

Date of First Visit: _____ Time: _____

Date of Second Visit: _____ Time: _____

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:

○ Business Liability Insurance ○ Oxygen Permit ○ Pharmacy License
○ State DME Permit ○ Surety Bond ○ 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

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 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, complete and review the information collection, and record keeping. 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) AND/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.

INTERVIEW OF INDIVIDUAL(S) PRESENT

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) ○ Y ○ N 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
○ Attach Copy

Does the supplier furnish contact information to beneficiaries at the time of delivery?
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:

_____

_____

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

ADDITIONAL COMMENTS