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

Date Ordered: Region/Director

Date of First Visit:		Time:	
Date of Second Visit:		Time:	

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:

☐ State Sales Tax Permit ☐ Business Liability Insurance ☐ Oxygen Permit
☐ DEA Certificate ☐ State DME Permit ☐ Other
☐ State Controlled Substance License ☐ 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. O Y O 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.
   O Copy Attached

4. O Y O 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:

O Storefront O Office Suite-Mall O Office Suite-Office Building
O Public Storage Facility O Private Residence O Warehouse Only
O Warehouse with Office O P.O/Commercial Mailbox
O 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? O Y O N
c. Is this facility normally visited by beneficiaries? O Y O N

6. O Y O N Is the facility handicapped accessible?
   O Photo Attached If no, how does the supplier accommodate handicapped beneficiaries?

_____

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

- Photo
  Attached

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. O Y O N Are the patient records maintained at this location?

    a) O Y O N Do these records include documentation of delivery, such as supplier delivery slips?

    b) O Y O N Do these records include supplier maintenance records?

    c) O Y O 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. O Y O 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: O White/yellow Pages O Directory Assistance O Internet Search

    What is the business telephone number?

    _____

LICENSING/CERTIFICATION

12. O Y O N Does the supplier have valid occupational and business licenses applicable to their
    O Copy business?
    Attached If "No", Explain: _____

13. OY O N Are the supplier's business, customers, and employees covered by comprehensive
    O Copy liability insurance with the NSC listed as a Certificate Holder?
    Attached

14. OY O N Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items for
    O Copy sale? If yes, provide proof of employment and copies of licenses/certifications for the
    Attached individual(s) providing this service?

    _____

    _____

    _____

    a) O Y O 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 ○ Copy Attached Does the supplier provide or plan to provide diabetic footwear?
If yes, provide proof of employment and copies of licenses/certifications for the individuals this service?
_____
_____
_____

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

INVENTORY

17. ○ Y ○ N ○Photo Attached Does the supplier have inventory in stock?
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) O Y O N O N/A
O 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. OY O N Is a current copy of the Supplier Standards provided to all Medicare patients?

OY O 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. O Y O N
O Copy Attached
Does the supplier furnish contact information to beneficiaries at the time of delivery, e.g. an equipment sticker label listing the supplier's name and telephone number?

21. OY O N
O Copy Attached
Does the supplier have a written complaint procedure and log established?
If "Yes", attach a copy of their complaint policy and complaint log.

22. OY O 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. OY O N
O Copy Attached
Does the supplier maintain documentation showing that it has provided equipment warranty information to beneficiaries, including how repairs and exchanges will be handled? If "Yes", attach a copy of an example.

24. OY O N Does the supplier rent Durable Medical Equipment?

25. ○Y ○ N ○N/A ○ Copy Attached 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 ○ Copy Attached 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

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ADDITIONAL COMMENTS