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

SITE INVESTIGATION FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

Date Ordered (mm/dd/yyyy)

Date of First Visit (mm/dd/yyyy)	Time
Date of Second Visit (mm/dd/yyyy)	Time

REASON FOR VISIT

◯ Application ◯ Appeal ◯ Non-Application Based ◯ Revalidation ◯ Reactivation

Supplier Type

Supplier Name

Authorized Rep

Supplier Number	National Provider Identifier (NPI)	
Address	Address 2	
City	State	ZIP Code

Phone

Was the site visit completed? ..... ◯ Yes ◯ No

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

For Non-Application based requests, attach copies of the following documents if checked:

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

☐ 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, describe: _____

a. What is the approximate size of the facility?

b. Is access to facility restricted (gated community, call box, etc.)? ..... ◯ Yes ◯ No

If yes, explain how access is granted:

c. Are there customers or signs of business activity during the inspection? ..... ◯ Yes ◯ No

d. Is this facility normally visited by beneficiaries? ..... ◯ Yes ◯ No

2. Is the facility accessible to the disabled? ..... ◯ Yes ◯ No

☐ Attach photo

3. Is there a permanent, visible sign with the supplier's business name posted on the facility? ..... ◯ Yes ◯ No

☐ Attach photo

If no, explain:

4. Are hours of operation posted? ..... ◯ Yes ◯ No

☐ Attach photo

If yes, where are hours of operation posted?

◯ Main entrance of building ◯ Entrance of supplier ◯ Both

Identify the facility's hours of operations:

◯ Open 24/7 (Open 24 hours a day, 7 days a week) ◯ By Appointment Only (no fixed days or hours)

List hours of operation below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total Hours:

5. Does the supplier share office space with other DME suppliers or other medical businesses? ..... ◯ Yes ◯ No

If yes, supply the following items:

Business Name

Type of Business	Owner(s)

6. Do the co-located businesses share any of the following items? (check all that apply)

☐ Entrances

☐ Patient Exam Rooms

☐ Inventory

If checked, describe and attach photos:

INTERVIEW OR INDIVIDUAL(S) PRESENT

1. Individual(s) Interviewed

Last Name	First Name

◯ Owner ◯ President ◯ Manager ◯ Administrator ◯ Other, explain: _____

Additional Information

2. Does the supplier have other locations that service Medicare beneficiaries? ..... ◯ Yes ◯ No

If yes, supply the following items. If additional space is needed, use the Comments section below.

Business Name

Address

City	State	ZIP Code

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Comments

3. Does the owner or any relatives own(ed) any other medical entities? ..... ◯ Yes ◯ No

If yes, supply the following items. If additional space is needed, use the Comments section below.

Owners Name	Relationship

Business Name

Address

City	State	ZIP Code

Comments

LICENSING/CERTIFICATION

1. For Non-application based requests, are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with the NPE as the certificate holder.) ◯ Yes ◯ No ◯ N/A Application Based

☐ Attach copy

If no, explain:

2. For Non-application based requests, does the supplier have valid state and federal licenses applicable to their business? ◯ Yes ◯ No ◯ N/A Application Based

☐ Attach copy

If no, explain:

3. Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items? ◯ Yes ◯ No

If yes, what are the name(s) and qualifications of those providing this service?

a. **Does the supplier fabricate items onsite?** ◯ Yes ◯ No

b. **If no,** does the supplier contract with other companies for the purchase of items necessary to fill orders? ◯ Yes ◯ No

c. **If yes,** identify the company:

Company Name	Phone

Street Address

City	State	ZIP Code

4. Does the supplier provide diabetic footwear? ◯ Yes ◯ No

☐ Attach copy

If yes, what are the name(s) and qualifications of those providing this service?

5. Does the supplier provide oxygen or oxygen related equipment? ◯ Yes ◯ No

☐ Attach copy

If yes, what are the name(s) and qualifications of those providing this service?

INVENTORY

1. Does the supplier have inventory stored on site? ◯ Yes ◯ No

☐ Attach copy

If yes, briefly provide description of inventory present:

If no, briefly describe why:

2. Does the supplier maintain an off-site storage facility? ◯ Yes ◯ No ◯ N/A Application Based

If yes, provide the following:

Street Address

City	State	ZIP Code

3. Does the supplier accept other types of health insurance? ◯ Yes ◯ No ◯ N/A Application Based

If yes, list:

4. Does the supplier rent Durable Medical Equipment? ◯ Yes ◯ No

a. **If yes, does the supplier directly service, maintain or replace DME items it rents to beneficiaries?** ◯ Yes ◯ No

b. **Do they have a service contract with another supplier?** ◯ Yes ◯ No

☐ Attach copy

If yes, identify the company:

Company Name	Phone

Street Address

City	State	ZIP Code

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

5. 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? ◯ Yes ◯ No

If no, explain the reasons why:

6. Does the supplier maintain proof of delivery of items furnished to beneficiaries? ◯ Yes ◯ No

☐ Attach copy

RECORDS AND PHONE

1. Where are the patient records maintained? (check all that apply)

☐ This location ☐ Off-site storage facility ☐ Electronically ☐ No patient records ☐ Supplier refusal/not permitted to view

2. What do these records include? (check all that apply)

☐ Physician ordering/referral documentation

☐ Beneficiary communications, such as questions received from beneficiaries and progress notes

☐ Documentation of delivery

☐ Maintenance, repairs, or exchanges

☐ Proof the supplier provided equipment warranty

☐ Attach copy

☐ 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

☐ Proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively

☐ Attach copy

If no, or supplier refused any of the above, provide an explanation:

3. Does the supplier have a written/electronic complaint policy/procedure established? ..... ◯ Yes ◯ No

If yes, attach a copy of their complaint policy/procedure.

4. Does the supplier have a written/electronic document for logging complaints? ..... ◯ Yes ◯ No

If yes, attach a copy of their complaint log.

5. Does the supplier have a business phone number (other than a cellular phone) listed in a local phone directory under the business name? ..... ◯ Yes ◯ No

If yes, list the phone number:

a. How was the phone number verified (check all that apply)?

☐ White/Yellow Pages ☐ Directory Assistance ☐ Search Engine

b. Was there phone activity during the site inspection? ..... ◯ Yes ◯ No

CONTACT WITH BENEFICIARY

1. Is a copy of the current Supplier Standards provided to all Medicare patients? ..... ◯ Yes ◯ No

2. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via phone ? ..... ◯ Yes ◯ No

If yes to third-party vendor, list company name(s).

If no, describe what methods the supplier uses to obtain new customers.

3. Does the supplier furnish contact information to beneficiaries at the time of delivery? ..... ◯ Yes ◯ No

Example: an equipment sticker label listing the supplier's name and phone number

☐ Attach copy

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. In taking pictures, I am attesting that no PII was captured in the photographs. 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 (mm/dd/yyyy)

ADDITIONAL COMMENTS