

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
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Reason for visit

☐ Application ☐ Appeal ☐ Non-application based ☐ Revalidation ☐ Reactivation

Supplier type

Supplier name

Authorized rep

Supplier number	National Provider Identifier (NPI)
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Address	Address 2
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City	State	ZIP code
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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: _____

Paperwork Reduction Act: 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, write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Facility information

1. Type of facility: ☐ Attach photo

- ☐ Storefront ☐ Suite-mall/Plaza ☐ Suite-office building ☐ Private residence ☐ Warehouse (only)
☐ Office-warehouse attached ☐ Other, describe: _____
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a. What is the approximate size of the facility? (42 CFR 424.57(c)(7)) _____

b. Is access to facility restricted (gated community, call box, etc.)? (42 CFR 424.57(c)(7)) ☐ 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? (42 CFR 424.57(c)(1)) ☐ Yes ☐ No

☐ Attach photo

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

(42 CFR 424.57(c)(7)) ☐ Yes ☐ No

☐ Attach photo

If no, explain:

4. Are hours of operation posted? (42 CFR 424.57(c)(7)) ☐ 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?

(42 CFR 424.57(c)(29)) ☐ 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? (42 CFR 424.57(c)(29)) (check all that apply)

- ☐ Entrances
☐ Patient exam rooms
☐ Inventory

If checked, describe and attach photos:

Interview or individual(s) present

7. Individual(s) interviewed

Last name

First name

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

Additional Information

8. Does the supplier have other locations that service Medicare beneficiaries? (42 CFR 424.57(c)(17)) ☐ 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

PTAN

Comments

9. Does the owner or any relatives own(ed) any other medical entities? (42 CFR 424.57(c)(17)) ☐ 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

10. 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.)

(42 CFR 424.57(c)(10)) ☐ Yes ☐ No ☐ N/A application based

☐ Attach copy

If no, explain:

11. For non-application based requests, does the supplier have valid state and federal licenses applicable to their business?

(42 CFR 424.57(c)(1)) ☐ Yes ☐ No ☐ N/A application based

☐ Attach copy

If no, explain:

12. 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 or custom fit items onsite? (42 CFR 424.57(c)(4)) ☐ 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
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Street address		
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City	State	ZIP code
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13. Does the supplier provide diabetic footwear? ☐ Yes ☐ No

☐ Attach copy

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

14. Does the supplier provide oxygen or oxygen related equipment? (42 CFR 424.57(c)(27)) ☐ Yes ☐ No

☐ Attach copy

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

Inventory

15. Does the supplier have inventory stored on site? (42 CFR 424.57(c)(4)) ☐ Yes ☐ No

☐ Attach copy

If yes, briefly provide description of inventory present:

If no, briefly describe why:

16. Does the supplier maintain an off-site storage facility? (42 CFR 424.57(c)(4))..... ☐ Yes ☐ No ☐ N/A application based

If yes, provide the following:

Street address

City	State	ZIP code
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17. Does the supplier accept other types of health insurance?..... ☐ Yes ☐ No ☐ N/A application based

If yes, list:

18. Does the supplier rent Durable Medical Equipment? (42 CFR 424.57(c)(5)) ☐ Yes ☐ No

a. If yes, does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

(42 CFR 424.57(c)(4), 42 CFR 424.57(c)(14)) ☐ Yes ☐ No

b. Do they have a service contract with another supplier? (42 CFR 424.57(c)(14))..... ☐ Yes ☐ No

☐ Attach copy

If yes, identify the company:

Company name	Phone
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Street address

City	State	ZIP code
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If no to any of the above, provide an explanation:

19. 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?

(42 CFR 424.57(c)(15)) ☐ Yes ☐ No

If no, explain the reasons why:

20. Does the supplier maintain proof of delivery of items furnished to beneficiaries? (42 CFR 424.57(c)(12)) ☐ Yes ☐ No

☐ Attach copy

Records and phone

21. Where are the patient records maintained? (42 CFR 424.57(c)(7)) (check all that apply)

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

22. What do these records include? (42 CFR 424.57(c)(7)) (check all that apply)

☐ Physician ordering/referral documentation (42 CFR 424.57(c)(28))

☐ Beneficiary communications, such as questions received from beneficiaries and progress notes (42 CFR 424.57(c)(7))

☐ Documentation of delivery (42 CFR 424.57(c)(7)), (42 CFR 424.57(c)(12))

☐ Maintenance, repairs, or exchanges (42 CFR 424.57(c)(14))

☐ Proof the supplier provided equipment warranty (42 CFR 424.57(c)(6))

☐ 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 (42 CFR 424.57(c)(5))

☐ Attach copy

☐ Proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively (42 CFR 424.57(c)(12))

☐ Attach copy

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

23. Does the supplier have a written/electronic complaint policy/procedure established?

(42 CFR 424.57(c)(19)) ☐ Yes ☐ No

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

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

If yes, attach a copy of their complaint log. (42 CFR 424.57(c)(13) and 42 CFR 424.57(c)(20))

25. Does the supplier have a business phone number (other than a cellular phone) listed in a

local phone directory under the business name? (42 CFR 424.57(c)(9)) ☐ 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

26. Is a copy of the current Supplier Standards provided to all Medicare patients? (42 CFR 424.57(c)(16)) ☐ Yes ☐ No

27. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals

via phone? (42 CFR 424.57(c)(11)) ☐ Yes ☐ No

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

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

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

(42 CFR 424.57(c)(12)) ☐ 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
