Funding Packet

Client information form

ImproveAbility
assistive technology consultants LLC

Section 1 - Client information

First name
Middle name
Last name
Street address
City
State
Zip
Telephone number
Date of Birth
Email
Marital status Single Married
Employment status Student Employed
Social Security Number
Gender M F
Place of residence Home Group home Assisted living
Hospice Custodial Care Facility Intermediate Care/MR Facility
Skilled Nursing Facility Other (specify)

Do you own, or have you previously owned a communication device? Y N N

Section 2 - Diagnosis information

Client medical diagnosis
Date of onset
Client communication diagnosis -
Date of onset
Is diagnosis result of an accident? Y N
If yes, date of accident
Type of accident

Section 3 - Family contact/legal guardian

Name

Telephone number

Alternate phone number

Email address

Relationship to Client

Section 4 - Speech pathologist/evaluator information

First name

Last name

Facility name

Street address

City

State

Zip

Telephone number

Fax number

Email address

State license number

ASHA number

Section 5 - Treating physician information

First name

Last name

Practice name

Street address

City

State

Zip

Telephone number

Fax number

Medicaid provider number (if applicable)

NPI number

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Section 6 - Insurance information

Note A copy of the front and back of all insurance cards must be included to prevent processing delays.

Medicare information (if applicable)

Medicare ID number ______ Is this a Medicare managed care? ☐ Y ☐ N

Medicaid information (if applicable)

Medicaid ID number ______ Is this a Medicaid Managed Care? ☐ Y ☐ N

Name of Managed Care Organization ______

Primary insurance information (if other than Medicare/Medicaid)

Note A copy of the front and back of all insurance cards must be included to prevent processing delays.

Insurance company name ______

Employer name ______

Policy holder name ______

Policy number ______ Group number ______

Policy holder date of birth ______

Policy holder address (if different from client)

Street address ______

City ______ State ______ Zip ______

Policy holder relation to patient ______

Secondary insurance information Insurance

company name ______

Employer name ______

Policy holder name ______

Policy number ______ Group number ______

Policy holder date of birth ______

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Policy Holder Address (if different from client)

Street address

City | State | Zip code

Policy holder relation to patient

Section 7 - Equipment requested

Product name		Model number		Price	
Product name		Model number		Price	
Product name		Model number		Price	
Product name		Model number		Price	

Section 8 - Shipping information

First name | Last name

Street address

City | State | Zip

Telephone number

I, the undersigned, verify that all information contacted herein is true to the best of my knowledge.

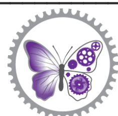
I, the undersigned, authorize the release of any medical or other protected health information for determining my benefits, payable for equipment and processing claims by CMS, my insurance carrier, or other medical/insurance entities.

I, the undersigned, understand that on occasion, funding or reimbursement barriers are encountered. I hear by authorize, ImproveAbility to release information related to my claim for funding to the Disability Law Center.

I, the undersigned, also release my protected health information related to my claim to Control Bionics, 745 Center St., Suite 300, Milford, OH 45150, who is acting as a third-party biller for ImproveAbility.

This form can only be signed by the client or their power of attorney.

Signature______________________________ Date________________



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Funding Process - PLEASE READ CAREFULLY

ImproveAbility is excited to provide you with your AAC equipment.

In order for this process to go smoothly, we need you, your SLP, and your doctor to work together to get all of the required paperwork.

You, your SLP, and your doctor may receive communication from our administrative team to help gather the paperwork. So, if you get an email or phone call from ImproveAbiltiy, please respond and assist us.

If you are not sure if the person calling is legitimate, feel free to reach out to us at the contact info below.

If we cannot get the paperwork together fully, we cannot complete the claim to your insurance.

Please note that the date of service for the claim is the date that we deliver your equipment. You MUST have insurance coverage on this date.

Here is a list of the paperwork required for your claim:

- Client Information Form (First 4 pages of this document)
- Doctor's full contact information - full name and office contact info
- Clear, legible copies of the front and back of your insurance cards
- Face to Face documentation (See detail info below)
- Prescription for your AAC equipment (We supply this to your doctor for signature)

You can contact us anytime to get an update on your case.

UNLOCK CODE
Medical insurance requires AAC devices to be locked to only provide access to the communication software. ImproveAbility charges a $25 unlock fee. We will be in touch prior to delivery to collect this fee so that you can receive your device unlocked. Please talk to your ImproveAbility consultant with any questions about this.

ImproveAbility, LLC
Phone: 512-522-1705
Fax: 888-501-1009
info@ImproveAbility.com

www.ImproveAbility.com

AAC Devices and Insurance Coverage

Most PALS (Patients with ALS) will need an AAC (Alternative and Augmentative Communication) device at some point during the progression of the disease.

If a PALS is on hospice, living in a nursing home, or inpatient in a hospital, they are not eligible to obtain these items through their medical insurance. ***If an AAC device is delivered to your home during these times, you will receive a bill for the full amount of the items.***

When a PALS is put on hospice, living in a nursing home, or inpatient in the hospital, your insurance company is paying the facility or hospice service for your overall care and will not pay for speciality equipment.

You may choose to go on hospice, enter a nursing home, or be an inpatient in a hospital for a variety of reasons. The main thing to know is that if you are in the process of obtaining an AAC device through insurance funding, you must notify ImproveAbility of your change of status.

The date of service of your AAC device is the date it is delivered to your home. So, your status on the date of delivery is what matters most.

It is your responsibility to notify ImproveAbility of your change in status. Most hospice organizations, nursing homes, or hospitals will not know to ask about this.

If you live in the state of Texas, we have the option to obtain equipment through the STAP program. You can be on hospice, in a nursing home, or inpatient in a hospital and receive equipment through STAP.

If you live outside of Texas, we can discuss options for loaner equipment or alternate funding options.

Face to Face Documentation for Speech Generating Device (SGD)

In order to provide an SGD, we must receive documentation of a Face to Face appointment with your doctor that notes **the medical need for a speech generating device.**

Please ask your doctor to perform a face to face visit as you are in need of a SGD (Speech Generating Device).

Guidance for Your Doctor's Visit

The face-to-face documentation must show that a doctor had an encounter with the patient, and it must be related to the primary reason the patient is receiving the SGD. As such, the face-to-face documentation must include several details to be considered complete. These requirements are as follows:

- The patient's name and date of birth
- Date of encounter
- Clear documentation that shows the patient was visually assessed by the doctor (head-to-toe assessment, review of systems assessment, vital signs, etc.)
- ***Describe the speech impairment and note that the provider is prescribing a SGD (Speech Generating Device)***
    - ***Example note: [Patient] was evaluated today by [Doctor] in regards to his diagnosis of [communication disorder diagnosis - ALS, Autism, etc]. [Patient] will benefit from a speech generating device that will permit [him, her] to communicate their medical needs.***
- All documentation must be in the pertinent portion of the medical record. (Checkbox forms are not acceptable - must be a narrative in the medical record.)
- Must be signed and dated by the doctor performing the assessment and must include the doctor's credentials.

NOTE TO DOCTOR'S OFFICE
Please send the face to face medical notes to:

ImproveAbility, LLC
Fax: 888-501-1009
info@ImproveAbility.com

Phone: 512-522-1705
www.ImproveAbility.com