SpeechVive— Reimbursement Checklist

Use the following checklist to gather the information required to pursue insurance reimbursement for the SpeechVive communication device.

**Please notify Abililife if there is any change in insurance coverage prior to receiving the SpeechVive device.

Complete the Following Documents included in the Packet:

Patient to Complete:

- Patient Information Page
- Communication Profile
- Assignment of Benefits Payment Terms and Conditions Form
- Patient Agreement

Physician to Complete:

- Physician's prescription (specifically lists SpeechVive)
- Physician chart notes documenting communication disorder and need for SpeechVive

Documents to obtain and include in Packet:

- Insurance cards (clear copies, front and back)
- Speech-language pathologist evaluation, if completed.

Please send the completed reimbursement packet to:

Abililife
Attn: SpeechVive Insurance Eligibility
via email orders@abililife.com or fax 844-335-8496

You may reach AbiliLife at

100 South Commons
Ste 102
Pittsburgh, PA 15212
Phone: 855-379-6283 Fax:
**Please retain a copy of the reimbursement packet for your records

SpeechVive— Patient Demographics

Please include pictures of the front and back of your insurance card(s)

Patient Information

Last Name:_____ First Name:_____ Middle Initial: _____

Social Security#: _____

Full Address: _____ Primary Phone: _____

_____ Alt. Phone: _____

_____ Email: _____

Shipping address:

Same as patient address _____

If the shipping address is different from the patient address please provide the full address:

Full Address:_____ Primary Phone: _____

_____ Alt. Phone: _____

_____ Email: _____

Care Partner/Support Person Information

Please provide the information of a contact person who is an emergency contact or is assisting the patient.
If the address is the same as above check box ☐

Last Name:_____ First Name: _____

Full Address:_____ Primary Phone: _____

_____ Alt. Phone: _____

_____ Email:_____

Relationship to patient: _____

Please read and complete the following forms. Failure to do so will delay the reimbursement process.

Communication Profile

Please complete the following communication profile. It is best to complete this with your care- partner to gain a clear understanding of your speech and communication.

Physical Impact

Explain the voice quality implications that you experience and how it impacts your life.

_____
_____
_____
_____

Communication and Interaction Skills

(Circle and provide detail)

1. Have any recent speech-language assessments been completed? Yes/No What were the results?

_____
_____
_____

2. Who best understands you and why?

_____
_____
_____

3. What is your estimate of the person's ability to complete the following tasks where 1 is no impact to their ability, 2 is mild impact to their ability, 3 is severe impact to their ability to complete the tasks

	No Impact	Mild Impact	Severe Impact
Instruct caregivers on things he/she needs done?	1	2	3
Communicate with unfamiliar listeners such as food service personnel?	1	2	3
Participate in social activities with friends and family?	1	2	3
Express specific ideas, like things he/she wants?	1	2	3
Interact with medical staff?	1	2	3
Communicate effectively in an emergency situation?	1	2	3
Talk with friends or family on the telephone?	1	2	3

4. When you are trying to communicate a specific idea (like something that happened at home), but you cannot be understood, do you. . .

- Realize you are NOT understood? YES/NO Describe:
- Keep repeating until you are understood? YES/NO Describe:
- Get angry or frustrated? YES/NO Describe:
- Quit and do something else? YES/NO Describe:
- Other:

5. Please describe your voice and what you believe will improve your communication.

_____
_____
_____

6. What are your goals for your communication?

_____
_____
_____

7. The SpeechVive device must be calibrated to your individual voice profile. Typically, this is completed via a Telehealth portal with a trained SpeechVive technician.
A tablet or smart phone will NOT work for the tele-calibration session.

Please indicate the computer setup you have for this session:

____Windows 7 or 10
____2 USB ports available
____Web camera
____Mac
____Internet connected
____I do not have technology available and would like someone from SpeechVive to contact me

 Please email this form to Orders@abililife.com or fax to 844-335-8496

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Patient Agreement

Customer Information

Name:_____
Phone:_____
Address:_____
City, State, Zip:_____
Date of Birth:_____

PATIENTS RIGHTS AND RESPONSIBILITIES

1. ABILILIFE delivers SpeechVive equipment in good order and repair. Patient agrees to operate the equipment for the purpose that it was designed andintended.
2. If the equipment malfunctions. DO NOT ATTEMPT TO REPAIR IT. Call SpeechVive immediately at (800) 392-3309. Our name and telephone number are on the equipment. If you have any questions as to the proper use of any product(s) provided to you by ABILILIFE, free consultation is available to you. The number to call is 800-392-3309.
3. Do not allow children or pets to pull, chew or otherwise disturb the cables and cords on the equipment.
4. I understand that the doctor or therapist is the only individual who has the authority to discontinue use of the equipment.
5. I agree to be responsible for any damages caused to the unit beyond normal wear and tear.
6. The department of Health and Human Services has established a fraud hotline for Government Health Plans, i.e. Medicare, Medicaid. The number to call is **1-800-HHSTIPS.**

If there are any questions or concerns at any time, please contact ABILILIFE, **(855)-379-6283**.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by ABILILIFE are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

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AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER, RELEASE, ACKNOWLEDGEMENT OF INSTRUCTIONS & RETURN DEMO

I request that payment of authorized insurance be made on my behalf to ABILILIFE for products and services that they provide me. I further authorize a copy of this agreement to be used in place of an original to release to the payers, any information needed to determine these benefits or compliance with current healthcare standards. ABILILIFE bills third party payers as a courtesy; I understand that I am fully responsible for all deductible, coinsurance and disallowable. Additionally, I acknowledge receiving instructions, and have demonstrated or verbalized my understanding in the proper use & care of the equipment or supplies received today described on this document & will follow them. I understand company business hours & ABILILIFE representative will be contacting me regarding my financial responsibilities related to this agreement. I certify acknowledge receipt & understand of the Company Patient Information Privacy Notice and that all information on this document is correct.

I have received ABILILIFE's Privacy Notice. ABILILIFE has given me the opportunity to discuss my questions and concerns about the security and privacy of my health information.

Distributor Signature X: Courtney Williamson Date/Time_____

Listed equipment set-up/&/or maintained per manufacturer guidelines; functional limitations. Environmental/architectural barriers/ electrical & safety checks per company policy; equipment use, warranty, availability of service & rights & responsibilities explained to patient/caregiver.

Signature of Patient X_____Date/Time_____

If signed by caregiver or other, please list the relationship and diagnosis related reason for not signing (Example: Husband, Sister, RN, etc. & "patient unable to sign due to Parkinson's, amputation, etc.")

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Authorization / Consent for Care I have been informed of the home care options available to me and authorize ABILILIFE, under the direction of the prescribing physician, to provide home medical equipment for my use in the home. I also acknowledge I did not receive any incentive to receive this product and I gave written permission for the DME company to speak with me about their DME products through any of the following methods of communication: phone, in person, mail, email, internet communication, or any other means necessary.

HIPAA NOTICE I acknowledge receipt of HIPAA PRIVACY NOTICE and allow ABILILIFE to use my medical information for the sole purpose of providing the requested equipment, determining medical necessity, repairs or insurance coverage.

PLAN OF CARE NOTICE: I received a plan of care for the use of the delivered equipment. The PLAN OF CARE details the appropriate need, proper use and care of the equipment.

I have read and agree to the terms and conditions above;

PATIENT SIGNATURE X_____DATE:_____

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Assignment of Benefits, Plan of Care, HIPAA Notice, Insurance, Terms and Conditions, Capped Rentals

Patient (First, Last):_____
Phone:_____

ASSIGNMENT OF BENEFITS I, the undersigned, hereby authorize all payments of medical benefits to be made directly to ABILILIFE, I understand that I am receiving service, supplies, or medical equipment from ABILILIFE before my insurance has been billed. In the event that your primary insurance co. denies payment, you have the option to return the equipment in good, original condition or purchase the delivered equipment within 7 days upon receipt of equipment. I understand that I am responsible for all the charges incurred if the primary or secondary insurance company does not fully cover or pay for the service, supplies, or medical equipment to the extent permitted by law. Right of title remains with ABILILIFE until paid in full. ABILILIFE has the right to have access to pick up equipment that has been denied. Any payment paid to you from the insurance carrier for this equipment is due to and shall be forwarded to ABILILIFE. I understand that ABILILIFE may or may not be a network provider for my private insurance carrier. You must notify an ABILILIFE employee 30 days in advance of any insurance termination or change of eligibility which could affect your responsibility for coverage, insurance payments and out of pocket costs.

RELEASE OF INFORMATION I further authorize ABILILIFE and its agents to obtain and use all medical information necessary for determining the extent of third-party coverage for processing insurance claims on my behalf. ABILILIFE is authorized to release this information to any insurance company or public or private agency that may be responsible for my medical expenses. ABILILIFE may also release medical information for the purpose of service or repairs.

ACKNOWLEDGEMENT OF PROPER DELIVERY, SAFETY, RETURNED GOODS I have received equipment in good working condition and I accept its delivery. I release ABILILIFE from all liability connected with the use, installation and instruction in the use of the equipment. The patient agrees to read the instructions before use. The buyer may cancel this transaction prior to midnight on the third following business day by written document or phone confirmation with an ABILILIFE staff member. ABILILIFE must be notified within 24 hours of delivery for any defective equipment. ABILILIFE will exchange out with a new item at no charge.

MEDICAL NECESSITY STATEMENT I certify that I have medical conditions relating to medical device delivered (SpeechVive) and these conditions are documented in my medical history.

OTHER FORMS: The patient has been given all additional documents including: Bill of Rights, Client Responsibilities, Supplier Standards and other applicable documentation.