



Date:

Client:

National Seating & Mobility Order:

To whom it may concern,

Our mutual patient is currently listed as being under hospice care. This patient either has an active order with us for a new mobility device/CRT equipment or currently has equipment under a rent-to-purchase with Medicare.

To proceed, please confirm the ICD-10 Dx that is being billed for hospice care. If the hospice diagnosis is unrelated to the diagnosis that qualifies the patient for the mobility device/CRT equipment, we can continue to process the order or bill the remaining months of the rental.

*****Per Medicare guidelines, a copy of the Hospice Election Statement Addendum from the Hospice provider is required for NSM to have on file in order to bill Medicare for a patient under Hospice care for the continued rental of the mobility device. ******

If there is any additional information required, please reach out directly at the number below.

If no additional information is needed, please sign and return the attached document confirming the Dx being billed for hospice via fax.

Thank you for your attention.

Sincerely,

National Seating & Mobility Inc.

Phone:



Hospice Election Statement Addendum

NSM Work Order:

Date of Service:

NSM Service Location:

Phone:

Fax:

Patient's Name:

Address:

Date of Birth:

Qualifying Diagnosis (for equipment):

Remaining Balance:

Please Complete the following

Hospice ICD- 10 Dx(s):

*****If the DX is unrelated to the qualifying diagnosis for the equipment, a copy of the Hospice Election Statement Addendum from the Hospice provider is required to be returned to National Seating & Mobility*****

If the Dx is the same, please select the following:

Hospice will take over payment ☐ Yes ☐ No

If hospice is not taking over payment, NSM will:

- 1) Cancel the current order for new equipment
- 2) Collect remaining balance from patient, patients family or designated representative if equipment has been delivered.
- 3) If unable to collect remaining balance, NSM will pick up the equipment

Hospice Provider:

Name:

Role/Title:

Confirmation Signature/Date:

Please return to the NSM fax number listed above. Thank you