RPM Plan of Care - Medicare

Patient Information

Patient Name: ________________________DOB: _________ Sex:________ Medicare #:________________

Address: ____________________________________City: __________________ State: _______ Zip:____________

Phone Number: _____________________________ SS #: ________________ Email:_______________________

Physician Information

Physician Name:____ NPI #: _______________________________

Address: __________________________________ City: ______________________ State: ______ Zip: ___________

Phone Number: _____________________FAX: ______________________ Email: ____________________________

Order: Accuhealth to enroll patient to telemonitoring services as detailed below. Frequency of readings will be as below, but, patient will hold ultimate decision should the patient choose not to adhere as ordered.

Goal: Patient will be placed on telemonitoring services within next 7 days with all readings to be sent to physician by software platform..

*****Specific Diagnosis Code for HTN: _________________ or DM: ________________ or Other: ________________**

Last MD Consultation/Initial MD assessment Date: ____________________________

Default Parameters

☐ Blood Pressure: Greater than 160/90 mmhg OR less than 85/50 mmhg
☐ Pulse: Greater than 100 b/m OR less than 50 b/m
☐ Blood Sugar: Greater than 350 mg/dl OR less than 60 mg/dl (Random & Fasting)
☐ Pulse Oximetry: Less than or equal to 90%
☐ Other: ____

Prescribed Parameters

☐ Blood Pressure: Greater than _____/_____ mmhg OR less than _____/_____ mmhg
☐ Pulse: Greater than _____ b/m OR less than _____ b/m
☐ Blood Sugar: Greater than _____ mg/dl OR less than _____ mg/dl (Random & Fasting)
☐ Other: ____

Telemonitoring Frequency: ☐ Daily as patient dictates Or Other: _____________

MD Disclosure, by signing below, I certify that this patient has met all of the CMS/federal requirements for Home Telemonitoring Services, and the patient has a medical need for these services. The patient has been initially assessed by me on the last MD apt date, stated above, I have verified that the patient and family/CG will safely support and assist in the telemonitoring program, the patient's home will safely support the electrical requirements needed for the health monitor and the patient will benefit from telemonitoring/RPM d/t the chronic illnesses listed. The patient is under my care, and I have authorized these services on the plan of care and will periodically review the plan. I order Accuhealth, and agree to be invoiced the sum of $45 per month to install and maintain telemonitoring and all applicable equipment in home via home visit or mail-order facilitation, and to satisfy the requirements of Telemonitoring CPT 99453 / 99454 / 99457, for as long as the service is deemed necessary.

__________________ __________ __________________ __________

MD Signature: Date: RN Signature: Date: