VerusCare
Changing home health care

❑ **DELIVERY TICKET**
❑ **PICK-UP TICKET**
❑ **ADD-ON TICKET**
❑ **REPAIR/REPLACE/SERVICE TICKET**
❑ **O_2 SIGNED DELIVERED**
❑ **O_2 SIGNED PICKED-UP**

Phone: (877) 828-3787
www.veruscare.com

Patient Name	Shirley Johnson	Facility Name	Hoar PT
Address	341 E Locust St	Phone	
City	Lod. State CA Zip 95240	Contact Name	
Phone	2093338121 VerusCare Tec: Carl.	Room #	
ORDER INFORMATION	Hospice Name: San Joaquin	Date 3/30/12	Time

❑ BED - Semi Elect w/mattress: ❑ 1/2 Rails ❑ Full Rails ❑ Rail Pads ❑ Extension ❑ Full Elect
❑ BED - H/D Full Elect w/mattress w: ❑ 1/2 Rails ❑ Full Rails ❑ Rail Pads ❑ Extension ❑ Full Elect
❑ APM (Stages 1-2) ❑ APM (Stages 1-4) ❑ LAL (Low Air Loss Stages 1-5) ❑ APP
❑ Gel overlay for Bed
❑ Trapeze ❑ Attach to Bed ❑ Floor Standing ❑ Hoyer Lift
❑ Table
❑ Concentrator with: ❑ Humidifier ❑ Nasal Cannula ❑ Mask ❑ Extended Tubing ____ ft.
❑ O2 Tanks ❑ M6-Portable ❑ E-Standard # Requested____ S/N: _____
❑ O2 Tank Carrier ❑ E Cart ❑ M6 Bag ❑ For Wheelchair Hrs: _____
❑ Nebulizer Lot #: _____
❑ Suction Machine _____
❑ Walker ❑ Std ❑ Wheeled ❑ Wheels & Seat

❑ Wheelchair with: ❑ Standard ❑ Lightweight ❑ H/D ❑ Recline ❑ ELR ❑ Gel Cushion
❑ Transfer Chair ❑ Broda Chair ❑ Geri Chair
❑ Shower Chair ❑ No Back ❑ Back
❑ Transfer Bench
❑ Commode ❑ Std ❑ H/D
❑ Add-on: Bed Alone
❑ Replacement: _____
❑ Additional Item: _____
❑ Additional Item: _____

Individual being instructed on use of equipment _____
Was Delivery / Setup satisfactory? Y_____ N_____ (Initial 1) If No, Reason _____
_____

We have rec'd and been instructed to our satisfaction on the following items:
APP Mattress_____ LAL Mattress_____ O2 concentrator_____ O2 Tanks/Regulator_____
Hoyer Lift_____ Misc:_____ (Initial all that applies)

Was Instruction / Training on items satisfactory? Y____ N____ (Initial 1)
If No, Reason _____
_____

If items were not setup / delivered, or patient instruction / training was skipped for any reason please Note:
Declined By:_____ Item Declined:_____ Initial_____ Reason: _____
_____

Delivery acknowledgement and Assignment of Benefits
I hereby acknowledge delivery / installation of the above indicated product(s). We have been instructed on these items to our satisfaction and all equipment is received in good working, clean condition. I am aware that I am free to call VerusCare Inc. with any complaints or issues of concern. I am also aware that VerusCare never guarantees payment or authorization of payment for any equipment or supplies when the payer is Medicare, Medi-Cal, Private Insurance or any other intermediary. VerusCare reserves the right to hold the responsible party liable for the payment(s) / expense(s) related to any product or service provided. I also give VerusCare Inc. the right to pick up equipment at any time if payment for equipment is denied by any payer, and in addition I also refuse payment for this equipment. I request payment, whether private party, Medicare, Medi-Cal, or any other private insurance, be made on my behalf to VerusCare Inc. for services and/or products furnished to me. I authorize any holder of medical information regarding me to release to the Health Care Finance Administration and its agents, including VerusCare Inc. any information needed to determine these benefits.

Signed_____ Date_____
Customer Signature / Responsible Party

Print Name_____ Title_____ Time_____

VerusCare
Changing home health care

❑ **DELIVERY TICKET**
❑ **PICK-UP TICKET**
❑ **ADD-ON TICKET**
❑ **REPAIR/REPLACE/SERVICE TICKET**
❑ **O_2 SIGNED DELIVERED**
❑ **O_2 SIGNED PICKED-UP**

Phone: (877) 828-3787
www.veruscare.com

Patient Name Shirley Johnson		Facility Name Home PT	
Address 341 E Locust St		Phone	
City L.D. State CA Zip 95240		Contact Name	
Phone 209 368 8762 VerusCare Tec:		Room #	
ORDER INFORMATION	Hospice Name:	Date	Time

❑ BED - Semi Elect w/mattress: ❑ 1/2 Rails ❑ Full Rails ❑ Rail Pads ❑ Extension ❑ Full Elect
❑ BED - H/D Full Elect w/mattress w: ❑ 1/2 Rails ❑ Full Rails ❑ Rail Pads ❑ Extension ❑ Full Elect
❑ APM (Stages 1-2) ❑ APM (Stages 1-4) ❑ LAL (Low Air Loss Stages 1-5) ❑ APP
❑ Gel overlay for Bed
❑ Trapeze ❑ Attach to Bed ❑ Floor Standing ❑ Hoyer Lift
❑ Table
❑ Concentrator with: ❑ Humidifier ❑ Nasal Cannula ❑ Mask ❑ Extended Tubing ____ ft.
❑ O2 Tanks ❑ M6-Portable ❑ E-Standard # Requested____ S/N: 1127003885
❑ O2 Tank Carrier ❑ E Cart ❑ M6 Bag ❑ For Wheelchair Hrs: 93.16
❑ Nebulizer Lot #: _____
❑ Suction Machine _____
❑ Walker ❑ Std ❑ Wheeled ❑ Wheels & Seat

❑ Wheelchair with: ❑ Standard ❑ Lightweight ❑ H/D ❑ Recline ❑ ELR ❑ Gel Cushion
❑ Transfer Chair ❑ Broda Chair ❑ Geri Chair
❑ Shower Chair ❑ No Back ❑ Back
❑ Transfer Bench
❑ Commode ❑ Std ❑ H/D
❑ Add-on: Bed Alarm (No charge per Jimmie. SJ will not pay)
❑ Replacement: _____
❑ Additional Item: _____
❑ Additional Item: _____

Individual being instructed on use of equipment _____
Was Delivery / Setup satisfactory? Y_____ N_____ (Initial 1) If No, Reason _____
_____

We have rec'd and been instructed to our satisfaction on the following items:
APP Mattress_____ LAL Mattress_____ O2 concentrator_____ O2 Tanks/Regulator_____
Hoyer Lift_____ Misc:_____ (Initial all that applies)

Was Instruction / Training on items satisfactory? Y____ N____ (Initial 1)
If No, Reason _____
_____

If items were not setup / delivered, or patient instruction / training was skipped for any reason please Note:
Declined By:_____ Item Declined:_____ Initial_____ Reason: _____
_____

Delivery acknowledgement and Assignment of Benefits

I hereby acknowledge delivery / installation of the above indicated product(s). We have been instructed on these items to our satisfaction and all equipment is received in good working, clean condition. I am aware that I am free to call VerusCare Inc. with any complaints or issues of concern. I am also aware that VerusCare never guarantees payment or authorization of payment for any equipment or supplies when the payer is Medicare, Medi-Cal, Private Insurance or any other intermediary. VerusCare reserves the right to hold the responsible party liable for the payment(s) / expense(s) related to any product or service provided. I also give VerusCare Inc. the right to pick up equipment at any time if payment for equipment is denied by any payer, and in addition I also refuse payment for this equipment. I request payment, whether private party, Medicare, Medi-Cal, or any other private insurance, be made on my behalf to VerusCare Inc. for services and/or products furnished to me. I authorize any holder of medical information regarding me to release to the Health Care Finance Administration and its agents, including VerusCare Inc. any information needed to determine these benefits.

Signed_____ Date_____
Customer Signature / Responsible Party

Print Name_____ Title_____ Time_____