Order taker's name

Order Intake

Referral source (i.e. web site)	Follow-up on order status with	Order Date
Referral source contact	Best day to follow-up	Phone
Referral relation to patient	Best time to follow-up	Email

Checklist ☐ Reship

☐ Expedite

☐ Checked product in stock with Shipping and Receiving
☐ Attached physician's Rx

Shipping / Delivery ☐ BLN Best Method

☐ UPS ☐ Ground
☐ USPS ☐ Next Day ☐ Second Day
☐ Other ____________

Ship to address ☐ Same as bill to address

If the system is current, check box and skip step

☐ Patient

Name | Marital status | Sex
BLN account-seq # | DOB | Age

Bill to address | Phone / E-mail
City | State | Zip
County

Emergency contact | Emergency phone
Relationship to patient | Emergency email

☐ Physician

Physician name | Company
Phone / Email | Fax

Physician address
City | State | Zip

DEA # | State license #
NPI #

☐ Products

				Hold
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note
Quantity	NDC #, catalog # or product description Testing Dosage / Testing Frequency	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code	Include date and note

☐ Primary Medical Insurance

BLN Client # | Group #
Plan Name | Group Name
ID #
Plan we are to bill | BLN Client #
Group #

Client ____________ % ☐ Diabetic Supply Coverage
Customer ____________ % ☐ DME Rider
Up to $ ____________ max out-of-pocket; after $ ____________ deductible

Effective Date | ☐ Eligible
Verified Date | How Verified
Verified By
Auth / Pre-cert #
Valid From Date | Valid To Date

Relationship to member | Member name
☐ Self (check and skip section) | DOB
☐ Spouse ☐ Child | Member ID #

☐ Secondary Medical Insurance

BLN Client # | Group #
Plan Name | Group Name
ID #
Plan we are to bill | BLN Client #
Group #
☐ Covers expenses applied to the deductiable of the primary
☐ Covers expesnes denied by the primary

Client ____________ % ☐ Diabetic Supply Coverage
Customer ____________ % ☐ DME Rider
Up to $ ____________ max out-of-pocket; after $ ____________ deductible

Effective Date | ☐ Eligible
Verified Date | How Verified
Verified By
Auth / Pre-cert #
Valid From Date | Valid To Date

Relationship to member | Member name
☐ Self (check and skip section) | DOB
☐ Spouse ☐ Child | Member ID #

Processing Notes

Include date and note

☐ Primary Pharmacy Insurance

BLN Client # | Group #
Plan Name | BIN #
ID # | PCN #
Relationship to insured
☐ Member ☐ Spouse ☐ Child | Person Code

☐ Secondary Pharmacy Insurance

BLN Client # | Group #
Plan Name | BIN #
ID # | PCN #
Relationship to insured
☐ Member ☐ Spouse ☐ Child | Person Code

Questions

☐ Diagnosis ☐ Type I
☐ Inject Insulin ☐ Type II

☐ Home health care episode in the home or facility

☐ Insurance questions ☐ The Blues

☐ Medicare ☐ 1947 or before 65+

Payment

☐ Check ☐ Past due
☐ Mastercard
☐ American Express
☐ Visa
☐ Discover

Balance due

Name on Credit Card

Credit Card Number

Credt Card Expiration Date

Routing

Initial	Routed to	Initial	Requested to
	Order Processing ☐ Pharmacy Date mm / dd / yy		Database Management Date mm / dd / yy
	Documentation Date mm / dd / yy		Management Date mm / dd / yy
	Insurance Verification Date mm / dd / yy		New Client / Group Entry Date mm / dd / yy
	Shipping Date mm / dd / yy		Other Date mm / dd / yy

Notes