TUFTS Health Plan

Durable Medical Equipment/Medical Supplies/Respiratory Equipment Companies Questionnaire

Date:_____________

Name of person completing this questionnaire and phone number:_______________________________

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Company name:____

Address:____

Director/business owner:_________________________ Principal contact:___________________________

Contact's phone number:_________________________ Contact's fax number:______________________

1. Please describe your service area and attach a list of all offices:

2. Describe your policy for both routine and emergent delivery:

3. List the days and hours your office is open:

4. Do you provide routine same day or next morning appointments? Yes ☐ No ☐

5. Do you have 24-hour access to provide patient assistance? Yes ☐ No ☐
   If so, describe how this is maintained:

6. Describe your patient education program and include any material you make available to patients:

7. If applicable, describe what your policies are for informing the community regarding home respiratory equipment in case of an emergency:

8. If applicable, describe how you would accommodate a patient who is receiving oxygen therapy and plans to travel out of state?