MBS IMAGING

Modified Barium Swallow Study
HOME HEALTH Check List

1. Please submit all required information listed below:

_____ MBSS/DYSPHAGIA CONSULT REQUEST FORM

_____ AUTHORIZATION FORM SIGNED BY PATIENT/RESPONSIBLE PARTY

_____ COPY OF PHYSICIAN'S WRITTEN AND SIGNED ORDER

_____ COPY OF PATIENT'S FACE SHEET WITH INSURANCE INFORMATION

_____CURRENT FULL LIST OF PATIENT DIAGNOSIS'S

_____ A COPY OF PATIENT'S MEDICARE, OR OTHER INSURANCE CARDS

PLEASE MAKE SURE THAT THE PATIENT'S HOME MEETS THE FOLLOWING:

_____THE FAMILY WILL ARRANGE FOR THE PATIENT TO BE BROUGHT OUT TO THE MBS IMAGING MOBILE UNIT. MBS IMAGING STAFF WILL NOT ASSIST WITH TRANSPORT OF THE PATIENT IN AND OUT OF THE HOME.

_____PATIENT'S HOUSE HAS ACCESSIBLE PARKING TO FIT MBS IMAGING BUS AND WILL NOT BLOCK TRAFFIC.

WE APPRECIATE YOUR REFERRAL – THANK YOU!

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

MBSS/VFSS: DYSPHAGIA CONSULT REQUEST FORM

Patient Name: _____ ☐ M or ☐ F

DOB: _____ AGE: _____ Ordering Physician's Name: _____

Facility: _____ Patient Hall / Room #: _____

Facility or Rehab Phone #: _____

Facility or Rehab Fax #: _____

SLP or Nurse Contact Number or Cell Phone: _____

REASON FOR MBSS/DYSPHAGIA CONSULT: (Check ALL that apply)

☐ s/s Aspiration ☐ change in P/O function ☐ diet upgrade ☐ least restrictive diet ☐ pleasure feed

Description of s/s of changes when eating/drinking:

_____

PATIENT CONDITION & DIET: (Check ALL that apply)

COGNITION: ☐ Good ☐ Fair ☐ Poor ALLERGIES_____

RESPIRATORY: ☐ Vent ☐ Trach 02 INFECTIOUS DISEASE_____

DIET STATUS: ☐ Peg ☐ NPO ☐ Regular Soft ☐ Mech Soft ☐ Puree ☐ Pudding ☐ Honey ☐ Nectar ☐ Thin

DENTAL STATUS: ☐ Teeth ☐ Dentures AMBULATORY STATUS: ☐ Walks independently ☐ Wheelchair

☐ Geri-Chair (*Please call office for special instruction)*

****** PLEASE SEND LIST OF DIAGNOSIS FROM YOUR FACILITY OR HOME HEALTH AGENCY. PLEASE LIST BELOW ANY OTHER PERTINANT SPEECH/SWALLOW DX OR INFORMATION REGARDING LAST HOSPITALIZATION.**

_____
_____
_____
_____
_____
_____

Please List Type of Insurance:

- ☐ Part A Covered Stay (SNF)
- ☐ Medicare Part B (speech therapy bill)
- ☐ Medicaid Only
- ☐ HMO/ Managed Care
- ☐ Private Insurance

Cash Pay _____

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

AUTHORIZATION FORM FOR MOBILE MODIFIED BARIUM SWALLOW STUDY

SECTION 1	Procedure Authorization

I hereby authorize MBSS Mobile to:

- Perform a Mobile Modified Barium Swallow (MBSS/VFSS) Study, in order to obtain an objective assessment of the swallowing function and to provide evaluation recommendations for diet, nutrition, compensatory strategies and other appropriate referrals.

SECTION 2	Billing Authorization

I hereby authorize:

- The release of any and all information required by MBSS Mobile for services furnished to me in order to process insurance claims on my behalf. In consideration of services rendered. I hereby assign and transfer to MBSS Mobile all rights, titles and interest benefits payable on all of my insurance carriers.
- The insurance carriers (Medicare Part B, Medicaid, or other Private Insurance) listed on the patient face sheet to pay directly to MBSS Mobile all benefits due under said policies by reason of services rendered herein. In the event the insurance carriers reimburse the patient in error, payment will be directly forwarded to MBSS Mobile for payment.

I will pay MBSS Mobile:

- The 20 percent co-pay and/or deductible remaining from Medicare Part B in the event I have no secondary coverage policy.
- The remaining balance if the patient's private insurance policy does not cover the 20 percent co-pay/or deductible, or if the patient's secondary policy does not cover an MBSS study.
- I will pay the account balance in full. (Either the full price of the test or the 20 percent co-pay /deductible) in the event Medicare Part B and/or Medicaid eligibility cannot be determined.

Patient's Printed Name: _____ Date: _____ / _____ / _____

Patient Signature: _____

Responsible Party or Power of Attorney Signature: _____

If received verbal consent only, please document in medical chart and sign here: _____

The facility must provide a copy of this signed Authorization by the patient (if able), the responsible party, or the person who has Power of Attorney prior to the MBSS being performed. The MBSS cannot be performed without this Authorization form.

******A photocopy of this authorization will be considered as effective and valid as the original******

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