travelling oxygen program
The MED Group Traveling Oxygen Program

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The MED Group Traveling Oxygen Program Purpose

The MED Group Traveling Oxygen Program will provide MED Members a reliable, cost containing and marketable service related to traveling oxygen clients. With timely and proper planning of service, traveling with oxygen can be accomplished comfortably and safe for the patients while permitting Members to coordinate and become more cost effective in providing oxygen services. Therefore, it will help in meeting the needs of a competitive market.

Specifically, participating MED Members will offer other MED Member’s clients the ability to be provided with oxygen services while traveling in the different areas of the United States.

Contact MED Customer Support (1-800-TALK MED) to receive a list of current participating members, as well as guidance in proceeding through the process of providing oxygen for a traveling client.
DMERC Medical Policy

As published in the Region B DMERC Supplier Manual Revision 36, September 2003, Chapter 17 Medical Policy OXY-6:

If a beneficiary travels out of their supplier’s usual service area, it is the beneficiary’s responsibility to arrange for oxygen during their travels. Medicare will only pay one supplier for oxygen during any one rental month.

Oxygen furnished by an airline to a beneficiary is non-covered. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.
Disclosure Statement

The MED Group Oxygen Traveling Program was developed to promote and provide MED Members a reliable, cost containing, marketable service related to clients traveling with oxygen. All MED Members will be subject to participate in the program when a member client visits their service area. MED Members will provide supplemental oxygen and equivalent equipment as required at the agreed price. Reciprocal service will be provided to all Members; along with acceptance of pricing and provision of equivalent equipment.

MED Members are responsible for keeping all information regarding their services updated. The information will include:

- service area,
- location of company and branches,
- business hours,
- contact person’s name and phone numbers,
- after hours contact name and phone numbers,
- list of equipment available, including all locations of operation, transfilling capabilities, and estimated transfilling time.
**Time Table of Providing Service**

1. The company providing the service to the traveling client will receive a minimum of **48 hours of notice**.

2. The set-up will be conducted during business hours whether the equipment is being picked up by the client or being delivered to the client.

3. An additional fee may be charged for non-business hour service to fit the client’s schedule.

4. The company providing the service to the traveling client will make available delivery at no additional cost as long as it is in the service area.
Service Areas

- The company providing the service to the traveling client will provide at no additional charge, delivery service within their standard service area.

- If the request is for service outside their service area the Company has the option to decline or charge an additional fee.
Equipment Provisions

- The company providing the service to the traveling client will make every effort to provide equivalent oxygen delivery modalities when possible.

- The company providing the service to the client is not required to have nor maintain inventory outside of their normal business practice.

- Deliveries and pickups will be made during business hours unless arrangements are made. Additional cost will then be negotiated between providers.

- If the traveling client is getting the equipment within the service area and then traveling outside the service area, it is the responsibility of the client to make return of the equipment to the company who provided the service to the traveling client.

- The client is responsible for any equipment damage or missing equipment.
Price Listing

- $60.00 plus $7.50 per day with a **seven (7) day minimum fee** (service period may be less) and a **thirty (30) day maximum fee** and service period.

- Minimum fee would be $112.50 and maximum $285.00.

- Fee includes stationary and/or portable(s): concentrator, LOX, and/or cylinders as needed by the patient (as does Medicare reimbursement).

- **Airport delivery – this is not part of the scope of this program.** If this service is provided, the company providing the service to the traveling client may charge an additional fee.

- **After hours delivery:** Deliveries and pickups will be made during business hours unless special arrangements are made. Any additional costs will be negotiated between providers.
Client Responsibilities

The client is responsible for:

1. Protecting the equipment from fire, water, theft, or other damage while it is the client's possession.

2. Using the equipment for the purpose for which it was prescribed and only on the client for whom it was prescribed.

3. Notifying the dispensing equipment company immediately of any equipment failure, defect or damage. In addition, the client is responsible for any incidental or consequential damages caused by delay or failure to notify the dispensing equipment company that equipment attention is needed.

4. Settlement, in full, all of their account(s) associated with the use of this equipment.

5. Returning the exact, original equipment to the dispensing equipment company. Example: High pressure cylinders when used for travel need to be REFILLED in the same container and NOT REPLACED with a similar size cylinder.

6. Providing ample notification (72 hours) to their primary equipment provider. This will allow arrangements for travel to be made as efficiently as possible.
## Traveling Oxygen Program Intake Form

Dates service needed __________________ Delivery time if required __________________

Patient name __________________ Profile phone _____________________________

Patient cell phone __________________________

Home address __________________ City __________ State ___ Zip ____________

Patient destination contact person

Destination address __________________ City __________ State ___ Zip ____________

Destination phone __________________ Emergency phone __________________________

Referring DME Company

Address __________________ City __________ State ___ Zip ____________

Contact person ___________________________ Phone ____________________________

Providing DME Company

Address __________________ City __________ State ___ Zip ____________

Contact person ___________________________ Phone ____________________________

Prescription (Provide Copy) ____________ Length of Need __________________________

Originating company must give 48-hour notice to providing DME Company.

☐ Delivery Address __________________ City __________ State ___ Zip ______________

☐ Patient pickup at provider office

**Equipment:** (Please indicate brand name)

☐ Concentrator: __________________ Model # __________________

☐ Cylinder (size) _________________ ☐ Liquid ____________________

☐ Regulator: __________________________ Model # __________________

☐ Liquid Portable: __________________ Model # __________________

☐ Transfill on Premises ☐ Transfill off Premises

☐ Estimated Transfill Time _________ ☐ Estimated Transfill Time ______________

☐ Other (please be very specific)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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Map of Service Areas

Under Construction – stay tuned.
Directory of Participating Members

Call MED Customer Service at 1-800-TALK-MED for up to date information on participating members and for help coordinating your patient’s travel.
Online Resources

www.aeromedic.com or www.outletmedical.com
www.portableoxygen.com
www.lungusa.org/support/traveloxygen.html
www.cysticl.org/handbook/html/traveling_with_oxygen.html
www.letsbreathe.com/new_page_2.htm
www.breathineasy.com/tips_air.html
www.oxygen4travel.com
www.mayoclinic.com/invoke.cfm?id=HQ01555
www.access-able.com/tips/oxy.html
www.travelwithoxygen.com
Acknowledgement Form
To Participate in The MED Group
Traveling Oxygen Program

Please provide the following information:

Company Name: ________________________________________________________

Branch Locations: (Attach additional sheet if necessary)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Contact Person/s: _______________________________________________________

Email Address/s: __________________________

Phone Number: _________________________________________________________

Fax Number: __________________________

Service Area: __________________________________________________________

Business Hours: ________________________________________________________

Equipment: Please indicate by checking appropriate box.

☐ Concentrator
☐ Cylinder (size)_____________
☐ Liquid
☐ Liquid Portable
☐ Transfill on Premises ☐ Transfill off Premises
☐ Estimated Transfill Time _______ ☐ Estimated Transfill Time ________
☐ Other (please be specific)_________________________________________
Disclosure Statement: The MED Group Traveling Oxygen Program was developed to promote and provide MED Members a reliable, cost containing, marketable service related to clients traveling with oxygen. All MED Members will be subject to participate in the program when a member client visits their service area. MED Members will provide supplemental oxygen and equivalent equipment as required at the agreed price. Reciprocal service will be provided to all Members along with acceptance of pricing and provision of equivalent equipment.

MED Members are responsible for keeping all information requested above updated by contacting the Customer Support Department at (800) 825-5633.

I have read and agreed to participate in The MED Group’s Traveling Oxygen Program as updated on 4/12/04.

Authorized
Company Signature: ________________________________________________________

Name & Title: _____________________________________________________________

Date: ___________________________________________________________________