Merion
Medical Supply

1100 First Avenue, Suite A
King of Prussia, PA 19406
Customer Service: 866.625.3615

IMPORTANT PATIENT INFORMATION FROM MERION MEDICAL SUPPLY: PLEASE READ

Your Physician has prescribed either durable medical equipment (DME) and/or an orthosis or diabetic supplies and shoes for you and the product will be supplied **by Merion Medical Supply that is a separate company that is a separate company from your healthcare provider's office**. Merion Medical Supply will bill your insurance company or Medicare for this product.

PLEASE REVIEW YOUR OPTIONS BEFOR SIGNING THE ATTACHED PATIENT PRODUCT AGREEMENT FORM AND AGREEING TO ACCEPT THE MERION MEDICAL PRODUCT:

OPTION 1: You may receive the product **NOW**, at the time of treatment, and **MERION** will bill your health insurance company. If your policy does not cover the cost of the product you receive , you will be responsible for any amount determined to be your financial responsibility, either due to deductibles, coinsurance or determinations of non-coverage, after we have submitted a claim to your health plan. Please be sure to provide Merion with your current health insurance information to ensure that a claim can be filed to your insurance.

OPTION 2: (NON-COVERED ITEM) YOU MAY CHOOSE TO PAY FOR THE ITEM IN FULL, AT THE TIME OF SERVICE.
Payment must be made by check or credit card only.

OPTION 3: RENTAL/PURCHASE OPTION: Some durable medical equipment (DME) can be rented, however Merion products are purchase only. If you do not wish to purchase the product(s) from Merion, you may request a prescription for the product directly from your Health Care Provider and you may consult your local pharmacy or medical supply company to fill your order.

RETURNS/EXCHANGES: Merion accepts returns for credit only within 14 days from the date of service. For returns call Merion at 866-625-3615. Product exchanges must be handles within 14 days by your Health Care Provider's office where you received the product.

BILLING QUESTIONS: For all Billing questions please call 866-625-3615

PLEASE PROVIDE THE PATIENT WITH THE COMPLETED COPY OF ALL ATTACHED PINK FORMS

	HCPC BILLING CODE	PRODUCT DESCRIPTION	HCPC BILLING CODE	PRODUCT DESCRIPTION
	A5500	DIABETIC SHOES	OTHER	
	A5512	HEAT MOLDED INSERTS	OTHER	
	A5513	CUSTOM MOLDED INSERTS	OTHER	
	E0100	CANE	OTHER	
	E0135	WALKER- ADJUSTABLE FOLDING		
	E0143	WALKER- FOLDING WITH WHEELS		
	E0146	SEAT ATTACHMENT		
	E0159	BRAKE ATTACHMENT		
	E0603	BREAST PUMP		
	E0676	INTERMITTENT LIMB COMPRESSION DEVICE		
	E0849	SAUNDERS CERVICAL TRACTION UNIT		
	L0626	LUMBAR ORTHOSIS W/ STAYS/PANELS		
	L0627	LUMBAR ORTHOSIS, SAGGITAL CONTROL		
	L1812	KNEE ORTHOSIS W/ JOINTS		
	L1830	KNEE IMMOBILIZER		
	E0118	KNEE WALKER		
	L1832	KNEE ORTHOSIS W/ ADJUSTABLE ROM HINGES		
	L1902	ANKLE FOOT ORTHOSIS, GAUNTLET STYLE		
	L1906	ANKLE FOOT ORTHOSIS, MULTI LIGAMENT STYLE		
	L1930	ANKLE FOOT ORTHOSIS, PLASTIC		
	L3908	WRIST BRACE, COCK-UP STYLE		
	L4350	ANKLE BRACE, STIRRUP STYLE		
	L4360	WALKING BOOT PNEUMATIC		
	L4361	WALKING BOOT, PNEUMATIC OTS		
	L4386	WALKING BOOT NON-PNEUMATIC		
	L4397	WALKING BOOT NON-PNEUMATIC OTS		
	L4396	NIGHT SPLINT CST		
	L4397	NIGHT SPLINT OTS		

PATIENT PRODUCT AGREEMENT & Rx

DO NOT COVER BARCODE

Dispensing Location**
(Required for Medicare)

Merion Medical Supply

REP. NAME

☐ **BILL ONLY** Do Not Replenish Product

① PRESCRIPTION

Patient Last Name _____ MI ____

Patient First Name _____

② Provider's Full Name:
First _____ Last _____

Provider's NPI # _____

By my signature, I am prescribing the item listed above. In my judgement, the above-prescribed item is medically indicated and necessary and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

③ *Provider's Signature* _____
For Medicare: No signature stamps
Provider's Signatue Date: ___/___/___
MUST BE ON OR BEFORE DATE OF SERVICE
For Medicare: Initial Date of Need ___/___/___

④ Patient Diagnosis ICD-10 CODE:

REQUIRED: QTY Items Ordered 1 2 3 4 LIMB: RT LT N/A

⑤ PATIENT INFORMATION (MANDATORY) BLOCK LETTERS ONLY

Billing Address _____
_____ Apt. # _____
City _____ State ____ Zip _____
Phone (Home) (____)____–____
(WK) (____)____–____ Sex M F
Date of Birth ___/___/___
Relationship to Insured _____ Self Spouse Child
Emergency Contact _____
Relationship _____ Phone (____)____–____

Date of Injury ___/___/___ **Required** for all injury claims.

☐ **Pre-Auth Faxed - Date:**
☐ **Insurance/Demos Attached**
☐ **Chart Notes Attached**
☐ **TOS Receipt Attached**
☐ **ABN Attached**
☐ **INPATIENT*/SNF**
☐ **TOS Discount Declined**

**Dispensing Location If Other Than Clinic Address (Required for Medicare)
☐ **Drop Ship to Patient** ☐ **Other**
Name _____
Address _____ Apt. # _____
City _____ State ____ Zip _____

⑥ PRIMARY INSURANCE INFORMATION

Guarantor's Name _____
Insurance Co. Name _____
Address _____
City _____ State ____ Zip _____
Phone (____)____-____ Guarantor's SSN _____
Policy # _____ Group # _____
Date of Birth ___/___/___

SECONDARY INSURANCE INFORMATION

Guarantor's Name _____
Insurance Co. Name _____
☐ **WORKER'S COMP** ☐ **AUTO**
Claim No. _____
Employer Address _____
Employer Phone (____)____-____
Adjustor Name _____
Adjustor Phone (____)____-____

⑦ I permit a copy of this authorization to be as valid as the original. I agree to use all products only in the manner for which they were intended and not to attempt to make any modifications or changes of any kind to the product. These products are to be utilized only as directed by my Health Care Provider. I agree that Merion Medical Supply is not responsible for defects in, or damages caused by, non-Merion Medical Supply products.

CONSENT FOR TREATMENT, PROOF OF DELIVERY, AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO HEALTH CARE PROVIDER, MERION MEDICAL SUPPLY OR ITS BUSINESS PARTNERS

I authorize Merion Medical Supply, or its Business Partners, to deliver and administer as necessary, the product and services prescribed by my Health Care Provider, and I acknowledge that I have received the product and such services. I authorize Merion Medical Supply, or its Business Partners, to submit a claim for such product to my insurer on my behalf, and I assign the benefits payable to my insurer for such product to Merion Medical Supply, or its Business Partners. I authorize my Health Care Provider and Merion Medical Supply, or its Business Partners, to release any of my medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise. I acknowledge that I have received and understand my Patient Rights and Responsibilities and the CMS supplier standards on the reverse side of this form. I also acknowledge that I have received and understand the information included on the tear-off form entitled "Important Information About The Medical Product You Are About To Receive." I also authorize Merion Medical Supply to contact me directly through my mobile phone using an automated dialer or broadcast messaging for additional information that may be needed to process my claim and/or a past due balance on my account.

Patient or Guarantor's Signature **Date** **Relation to patient, if other than self**

Your signature on this form indicates that you received the prescribed product, undamaged, and the Merion Medical Supply Notice of Privacy Practices. Call 1-888-225-4398 for billing questions. MERION MEDICAL SUPPLY ACCEPTS RETURNS FOR CREDIT WITHIN 14 DAYS FROM SERVICE BY CALLING MERION MEDICAL SUPPLY CUSTOMER SERVICE AT 1-888-225-4398.

⑧ **PAYMENT FORM** ☐ **Visa** ☐ **Mastercard** ☐ **Discover** ☐ **American Express** ☐ **Check** *make payable to Merion Medical Supply and attach to form*

Cardholder _____ Cardholder
Card Number _____ Signature:
Amount _____ Expiration Date _____

**Checked box means patient was later determined to be an inpatient: clinic will be billed directly for this product.*

SUPPLIER STANDARDS

MERION Medical Supply adheres to the following standards as required by the Centers for Medicare and Medicaid Service:

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirement
2. A supplier must provide complete and accurate information on the DMEOPS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contact with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty
7. A supplier must maintain a physical facility on an appropriate site
8. A suppler must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of mobile communications devices is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number, a summary of the compliant, and any actions taken to resolve it
21. A supplier must agree to furnish CMS any information required by the Medicare statue and implementing regulations
22. All suppliers of DMEPOS and other items and services must be accredited by a CMS approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.
23. All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for 3 months after it is operation without requiring a new site visit.
24. All DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with DMEPOS quality standards.
25. ALL DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date-May 4, 2009
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

CLIENT/PATIENT BILL OF RIGHTS AND RESPONSIBILITES We believe that all clients/patients receiving service from MERION Medical Supply should be informed of their rights.
Therefore you are entitled to:

- Receive reasonable coordination and continuity of service from the referring agency for home medical equipment services.
- Receive a timely response from KRATOS Medical Supply when homecare services/care is needed or requested.
- Be fully informed in advance about service/care to be provided and any modifications to the Plan of Service/Care.
- Participate in the development and periodic revision on the Plan of service/care.
- Informed consent and refusal of service/care of treatment after the consequences of refusing service/care or treatment are fully presented.
- Be informed in advance of the charges, including payment for service/care expected from third parties and any charged for which the client/patient will be responsible.
- Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality
- Be able to identify visiting staff members through proper identification
- Voice grievances/complaints or recommend changes in policy, staff or service/care without restraint, interference, coercion, discrimination or reprisal
- Choose a health care provider
- Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information.
- Receive appropriate service/care without discrimination in accordance with physician orders
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's responsibilities
- Be informed of provider service/care limitations
- Be informed of client/patient rights under state law to formulate advance care directives
- Be informed of anticipated outcomes of service/care and of any barriers in outcome achievement
- Receive reasonable coordination and continuity of services from the referring agency for home medical equipment services
- Receive a timely response from MERION Medical Supply when homecare services or care are needed or requested
- Be fully informed in advance about service or care to be provided, and any modifications to the Plan of Service or the Plan of Care
- Participate in the development and periodic revision of the Plan of Service or the Plan of Care

CLIENT RESPONSIBILITES

- Client agrees that rental equipment will be used with reasonable care, not altered or modified, and returned in good condition (normal wear and tear excepted).
- Client agrees to promptly report to MERION Medical Supply any malfunctions or defects in rental equipment so that repair/replacement can be arranged
- Client agrees to provide MERION Medical Supply access to all rental equipment for repair/replacement, maintenance, and/or pick-up of the equipment
- Client agrees to use the equipment for the purposes so indicated and in compliance with the physician's prescription
- Client agrees to keep the equipment in their possession and at the address, to which it was delivered unless otherwise authorized by MERION Medical Supply
- Client agrees to notify MERION Medical Supply of any hospitalization, change in customer insurance, address, telephone number, physician, or when the medical need for the rental equipment no longer exists
- Client agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits are paid directly to MERION Medical Supply for any services furnished by MERION Medical Supply
- Client agrees to accept all financial responsibility for home medical equipment furnished by MERION Medical Supply
- Client agrees to pay for the replacement cost of any equipment damaged, destroyed, or lost due to misuse, abuse or neglect
- Client agrees not to modify the rental equipment without the proper consent of MERION Medical Supply
- Client agrees that any authorized modification shall belong to the titleholder of the equipment unless equipment is purchased and paid for in full
- Client agrees that title to the rental equipment and all parts shall remain with MERION Medical Supply at all times unless equipment is purchased and paid for in full
- Client agrees that MERION Medical Supply shall not insure or be responsible to the client for any personal injury or property damage related to any equipment; including that caused by use or improper functioning of the equipment; the act or omission of any other third party, or by any criminal act or activity, war, riot, insurrection, fire or act of God.
- Client understand that MERION Medical Supply retains the right to refuse delivery of service to any client at any time
- Client agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken

Product returns for credit: Merion Medical accepts returns for credit only within 14 days from the date of service. Please call 1-866-625-3615
And a return specialist will help you. Product exchanges are handled at the clinic within 14 days from the date of service.

HIPAA NOTICE OF PRIVACY PRACTICES for Merion Medical Supply

MEDICAL INFORMATION PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how We may use information about you and when We can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information We maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change Our privacy practices and the terms of this notice. If We make a material change to Our privacy practices, We will provide a revised notice by direct mail to you reflecting that change within 60 days of the change and We will otherwise post the revised notice in our office.

We reserve the right to make any revised or changed notice effective for information We already have and for information that We receive in the future.
**For purposes of this Notice of Privacy Practices, "We" or "Us" refer Merion Medical Supply*

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure yourprivacy is protected.
- **We have the right to use and disclose** health information for your treatment, to pay for your health care and to operate Our business. For example, We may use or disclose your health information:
- **For Payment** of healthcare services we provide you. For example, we may tell your health plan about equipment you will receive to determine whether your plan will cover the cost.
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- **For Treatment**. We may use and disclose your records to provide, coordinate or manage your treatment
- For Health Care Operations. We may use or disclose health information in order to support the business activities of this facility. These activities include but are not limited to , quality assessment, employee review, legal services, licensing, and conducting or arranging for other business activities.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law as of February 17, 2010.
- **For Reminders.** We may use or disclose health information to send you reminders about your *Benefits* or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an *Emergency*, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, We will use Our best judgment to decide if the disclosure is in your best interests.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceeding**s such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an *Emergency* or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
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- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on Our behalf or provide Us with services if the information is necessary for such functions or services. Our business associates are required, under contract with Us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in Our contract.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your *Plan* through which you receive coverage.

Except for uses and disclosures described and limited as set forth in this notice, We will use and disclose your health information only with a written authorization from you. Once you give Us authorization to release your health information, We cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if We have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

You have the right to ask to restrict uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on *Dependent* access that authorize your dependents to request certain restrictions. **Please note that while We will try to honor your request and will permit requests consistent with Our policies, We are not required to agree to any restriction.**

You have the right to request that a provider not send health information to Us in certain circumstances if the health information concerns a health care item or service for which you have paid the provider out of pocket in full.
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You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

You have the right to see and obtain a copy of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, We may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If We deny your request, you have the right to have the denial reviewed. If We maintain an electronic health record containing your health information, you have the right to request that We send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

You have the right to ask to amend information We maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested *Amendment*. Mail your request to the address listed below. If We deny your request, you may have a statement of your disagreement added to your health information.

You have the right to receive an accounting of certain disclosures of your information made by Us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which Federal law does not require Us to provide an accounting.

You have the right to a paper copy of this notice.

Contacting us If you have any questions about this notice or want to exercise any of your rights, please call the phone number on the back of your ID card or you may contact the Merion Medical Supply at 1-866-625-3615

Submitting a Written Request. Mail to Us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for *Amendments* to your record, at the following address:

Merion Medical Supply
1100 First Ave
Suite A
King of Prussia Pa 19406

Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint

with Us at the address listed above.

You may also notify the Secretary of the *U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.