

# Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

## SUPPLIER INFORMATION

Supplier Type:

Supplier Number: 1146390001

Supplier Name: GV MEDICAL EQUIP & SUPPLY INC.

National Provider Identifier(NPI): 1326195926

Authorized Representative: RAMIN R BAROUKH

Telephone Number: 3105426575

Address: 21032 HAWTHORNE BL

City/State/Zip Code: Torrance, CA 90503

Reason for Visit: Revalidation

## VISIT DATES

Date of First Visit

12/19/2023



Time of First Visit

03:30 PM

Date of Second Visit



Time of Second Visit

## FACILITY INFORMATION

1. Type of Facility

Storefront

- ☐ Yes  
☒ No

Suite-Mall/Plaza

- ☒ Yes  
☐ No

Suite-Office Building

- ☐ Yes  
☒ No

Private Residence

- ☐ Yes  
☒ No

Warehouse (Only)

- ☐ Yes  
☒ No

Office-Warehouse Attached

- ☐ Yes  
☒ No

Other

- ☐ Yes  
☒ No

If "Other", Please Describe

Attach Photo

- ☒ Yes  
☐ No

Photo Upload



Latitude: 33.8389668  
Longitude: -118.3532052  
Date: 12/19/2023 03:28 PM PST

a. What is the approximate size of the facility?

1600 square feet

b. Is access to facility restricted (gated community, call box, etc)?

- ☐ Yes  
☒ No

c. Are there customers or signs of business activity during the inspection?

- ☒ Yes  
☐ No

d. Is this facility normally visited by beneficiaries?

- ☒ Yes  
☐ No

e. If a home based business, are all local zoning requirements met?

- ☐ Yes  
☐ No  
☒ N/A

2. Is the facility accessible to the disabled?

- ☒ Yes  
☐ No

If "No", how does the supplier accommodate disabled persons?

Attach Photo

- ☒ Yes  
☐ No

### Photo Upload



Latitude: 33.8389668  
Longitude: -118.3532052  
Date: 12/19/2023 03:28 PM PST

3. Is there a permanent, visible sign with the supplier's business name posted on the facility?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0749. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244- 1850.

4. Are hours of operation posted?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



Latitude: 33.8389668  
Longitude: -118.3532052  
Date: 12/19/2023 03:29 PM PST

Open 24/7 (Open 24 hours a day, 7 days a week)

OR

☐ Yes

☒ No

By Appointment Only (no fixed days or hours)

AND/OR

☐ Yes

☒ No

Please list hours of operation below

Monday

9:00 AM to 5:00 PM

Tuesday

9:00 AM to 5:00 PM

Wednesday

9:00 AM to 5:00 PM

Thursday

9:00 AM to 5:00 PM

Friday

9:00 AM to 5:00 PM

Saturday

By appointment only

**Sunday**

Closed

**Total Hours**

45 hours

5. Was the site visit completed? If unable to conduct site visit for any reason (supplier not operational or inspection refused), please explain in the Additional Comments section at the end of this form.

- ☒ Yes  
☐ No

**INTERVIEW OF INDIVIDUAL(S) PRESENT**

6. Individual(s) Interviewed

- ☐ Owner  
☐ President  
☐ Manager  
☒ Administrator  
☐ Other

**Owner's Last Name**

**Owner's First Name**

**President's Last Name**

**President's First Name**

**Manager's Last Name**

**Manager's First Name**

**Administrator's Last Name**

Baroukh

**Administrator's First Name**

Ramin

**If "Other", Please Describe**

**Additional Information**

7. The supplier must provide a list of all owners and management with day-to-day control, including name and title.

**Attach Copy**

- ☐ Yes  
☒ No

**8. Does the supplier have other locations that service Medicare beneficiaries? If additional space is needed, please use the Additional Comments section at the end of this form.**

- ☐ Yes  
☒ No

If "Yes", please supply the following items:

**Business Name**

**Address**

**City**

**State**

**Zip Code**

**PTAN**

**9. Does the owner or any relatives own(ed) any other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.**

- ☐ Yes  
☒ No

If "Yes", please supply the following items:

**Owner's Last Name**

**Owner's First Name**

**Relationship**

**Business Name**

**Address**

**City**

State

Zip Code

10. Does the supplier share office space with other DME suppliers or other medical businesses?

- ☐ Yes  
☒ No

If "Yes", please supply the following items:

Business Name

Type of Business

Owner's Last Name

Owner's First Name

Attach Photo

- ☐ Yes  
☒ No

Do the co-located businesses share any of the following items?

a. Entrances

- ☐ Yes  
☐ No

b. Office personnel/ownership

- ☐ Yes  
☐ No

c. EIN

- ☐ Yes  
☐ No

d. Telephone

- ☐ Yes  
☐ No

e. Inventory

- ☒ Yes  
☐ No

If "Yes" to any of the above, please describe and attach photos.

RECORDS & TELEPHONE

11. Are the patient records maintained (check all that apply)

at this location?

- ☒ Yes  
☐ No

at an off-site storage facility?

- ☐ Yes  
☒ No

electronically?

- ☒ Yes  
☐ No

a) Do these records include physician ordering/referral documentation?

- ☒ Yes  
☐ No

b) Do these records include beneficiary communications, such as questions received from beneficiaries and progress notes?

- ☒ Yes  
☐ No

c) Do these records include documentation of delivery?

- ☒ Yes  
☐ No

d) Do these records include documentation of maintenance, repairs, or exchanges?

- ☒ Yes  
☐ No

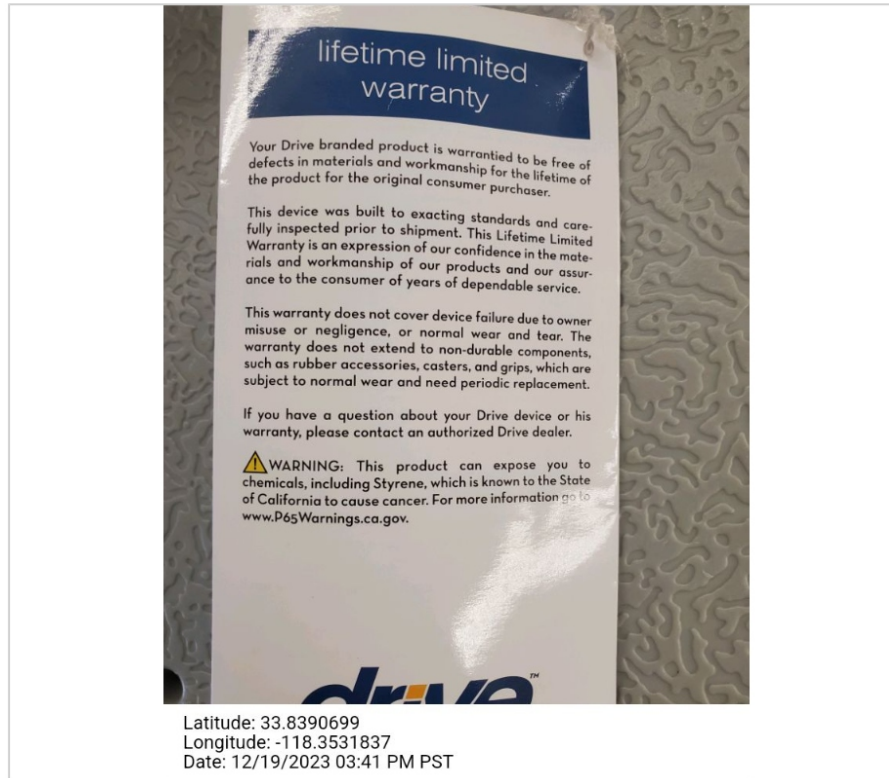
e) Do these records include proof the supplier provided equipment warranty?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



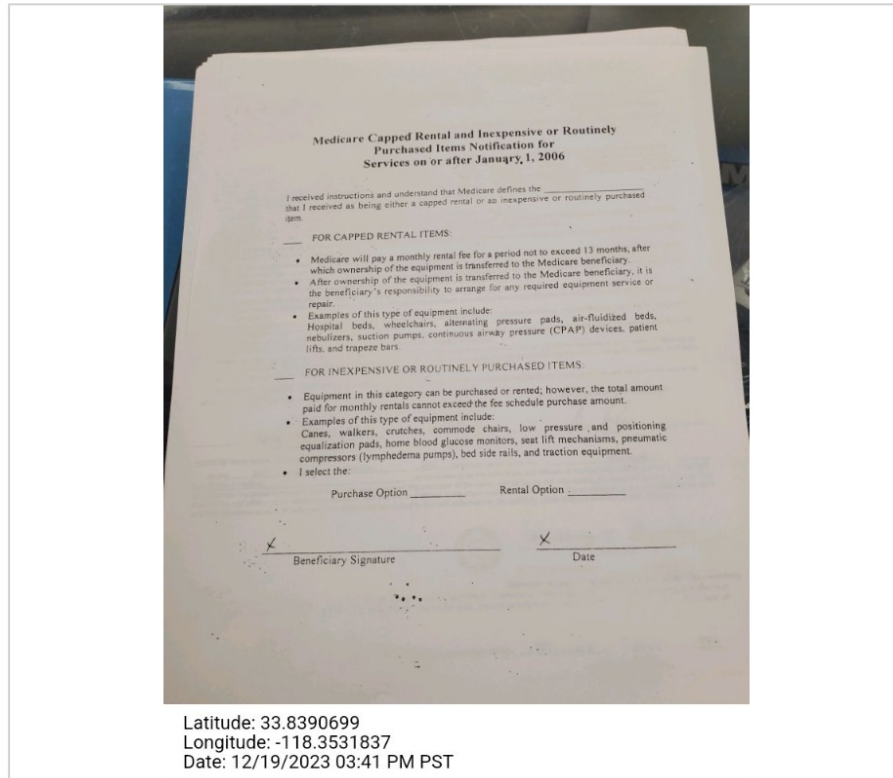
f) Do these records include proof the supplier advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the capped rental policy?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



g) Do these records include proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload

GV MEDICAL EQUIPMENT & SUPPLY, INC.  
21032 Hawthorne Blvd.  
Torrance, CA 90503  
Phone (310) 542-6575  
Fax (310) 542-6585  
Fed Tax ID# 95-4694341

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

INSTRUCTION TO USE/OPERATE THE MEDICAL SUPPLY/EQUIPMENT:

INITIALS OF THE PATIENT/CAREGIVER \_\_\_\_\_

1. A full description of the delivered item based on the doctor's prescription.
2. The customer should try and fit the delivered item and make sure it is the right ordered item.
3. Remind the customer of seven (7) days return policy in the same condition, with the original receipt and package. No refunds/exchange on diapers, stockings, and reusable panties.
4. Inform the customer about the manufacturer warranties and give them a copy of the warranty.
5. Give them instruction how to clean and maintain the product inside and out, and, the infection control issues related to the use of the delivered item.
6. The delivered items are in good working condition and all the components and accessories are included such as; \_\_\_\_\_
7. Demonstrate the feature, routine use and trouble shooting of the delivered item based on manufacturer's manual.
8. Inform the customer the appropriate safety considerations.
9. The item's delivery date is on time as per customer/doctor's instruction.
10. The customer is satisfied with the delivered item.
11. Give our contact information and regular business hours to the customer for their questions/inquiry.

Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:43 PM PST

If "No" to any of the above, please explain

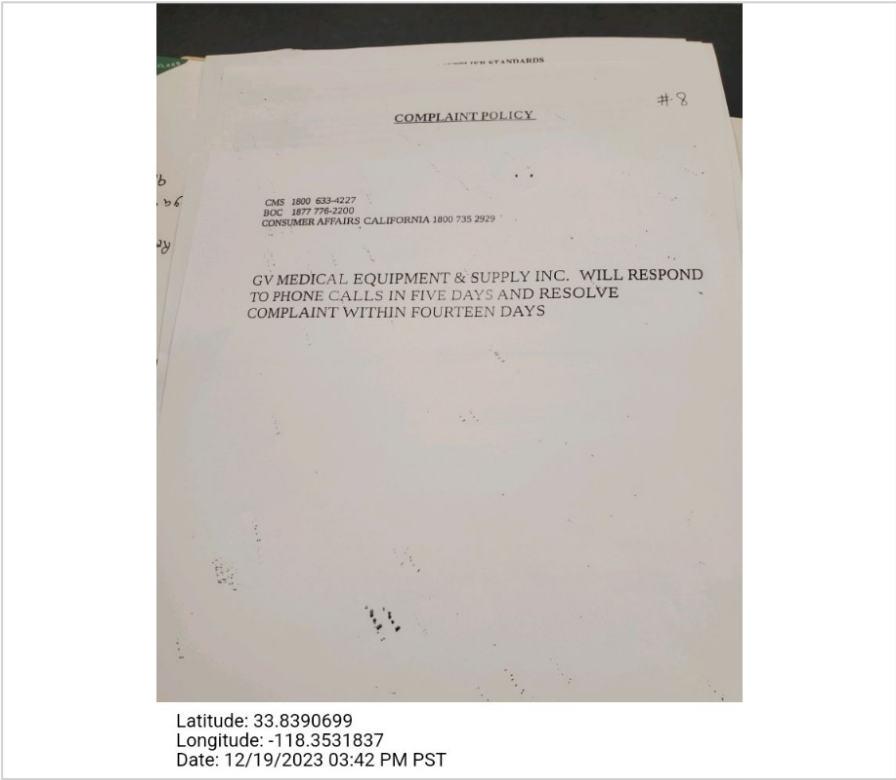
12. Does the supplier have a written complaint policy/procedure established and document for logging complaints?

- ☒ Yes  
☐ No

If "Yes", please attach a copy of their complaint policy and complaint log.

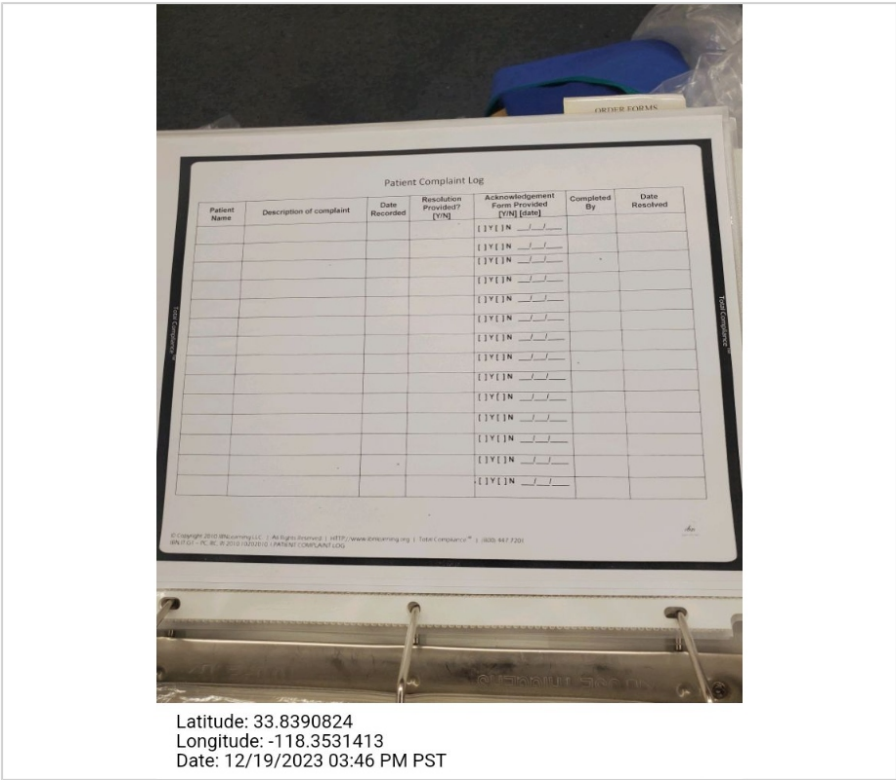
- ☒ Yes  
☐ No

Complaint Policy Photo Upload



Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:42 PM PST

Complaint Log Photo Upload



Latitude: 33.8390824  
Longitude: -118.3531413  
Date: 12/19/2023 03:46 PM PST

13. Does the supplier have a business phone number (other than a cellular phone) listed in a local telephone directory under the business name?

- ☒ Yes  
☐ No

Please list the phone number

310-542-6575

a) How was the phone number verified (check all that apply)?

White/Yellow Pages

- ☒ Yes  
☐ No

Directory Assistance

- ☒ Yes  
☐ No

b) Was there telephone activity during the site inspection?

- ☒ Yes  
☐ No

#### LICENSING/CERTIFICATION

14. Are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with NSC as the certificate holder.)

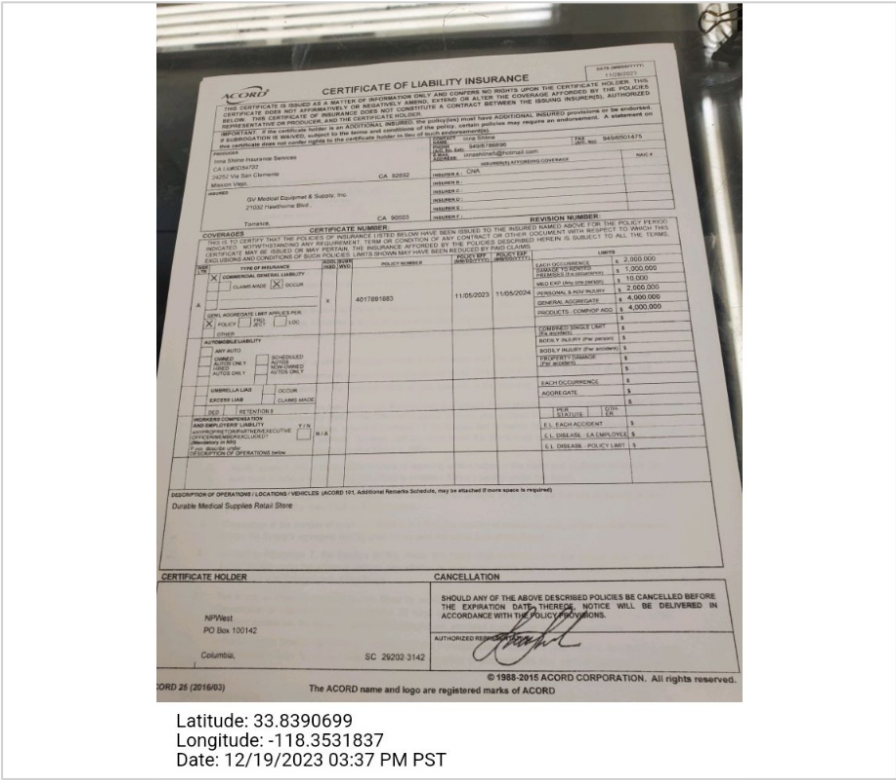
- ☒ Yes  
☐ No

If "No", please describe

Attach Photo

- ☒ Yes  
☐ No

Photo Upload



15. Does the supplier have valid state and federal licenses applicable to their business?

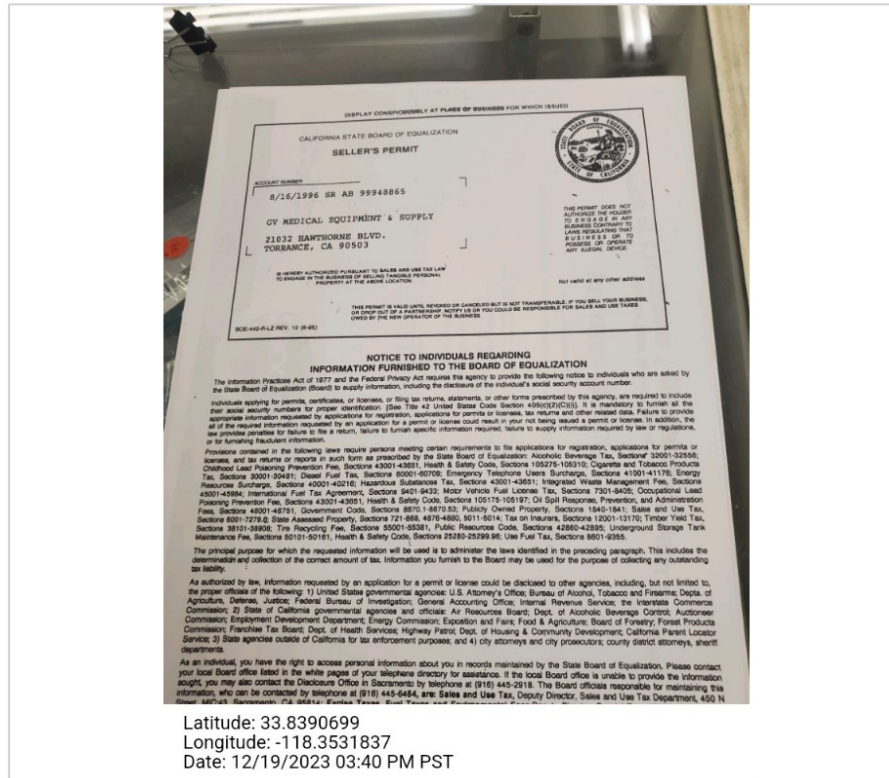
If "No", please describe

- ☒ Yes
- ☐ No

Attach Photo

- ☒ Yes
- ☐ No

## Photo Upload



Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:40 PM PST

16. Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items?

- ☐ Yes
- ☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
- ☒ No

a) Does the supplier fabricate items onsite?

- ☐ Yes
- ☒ No

If "No", does the supplier contract with other companies for the purchase of items necessary to fill orders?

- ☐ Yes
- ☒ No

If "Yes", please identify the company:

Company Name

Street Address

City

State

Zip Code

Telephone #

17. Does the supplier provide diabetic footwear?

- ☐ Yes  
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes  
☒ No

18. Does the supplier provide oxygen or oxygen related equipment?

- ☐ Yes  
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes  
☒ No

## INVENTORY

19. Does the supplier have inventory stored on site?

- ☒ Yes  
☐ No

Briefly provide description of inventory present

The provider stated they have the following inventory; Wheelchairs Walkers Canes,

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:31 PM PST

20. Does the inventory present support the supplier's billing history?

- ☐ Yes  
☒ No

N/A (No billing history)

Yes

a) If "No", please obtain invoices and/or contracts to verify the purchase of DME supplies.

- ☒ N/A  
☐ Attach Photo

Vendor Name

Street Address

City

State

Zip Code

Telephone #

b) Does the supplier maintain an off-site storage facility?

- ☐ Yes  
☒ No

If "Yes", please provide

Street Address

City

State

Zip Code

c) Does the supplier accept other types of health insurance?

- ☒ Yes  
☐ No

If "Yes", please list

The provider stated they accept the following insurance; Aetna, Blue Cross, Healthnet and all Primary insurance.

21. Does the supplier rent Durable Medical Equipment?

- ☒ Yes  
☐ No

a) If "Yes", does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

- ☒ Yes  
☐ No

b) Do they have a service contract with another supplier?

- ☐ Yes  
☒ No

If "Yes", please identify the company

- ☐ Yes  
☐ No

Company Name

Street Address

City

State

Zip Code

Telephone #

If "No" to any of the above, please provide an explanation:

The provider stated they do not have any contracts with other companies.

Attach Photo

- ☐ Yes  
☒ No

#### CONTACT WITH BENEFICIARY

22. Is a copy of the current Supplier Standards provided to all Medicare patients?

- ☒ Yes  
☐ No

23. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via telephone?

- ☐ Yes  
☒ No

If "Yes" to third-party vendor, list company name(s).

If "No", please describe what methods the supplier uses to obtain new customers?

Notes

The provider stated that they take walk in and doctor referrals.

24. Does the supplier furnish contact information to beneficiaries at the time of delivery? Example: an equipment sticker label listing the supplier's name and telephone number

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:39 PM PST

25. Does the supplier 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?

- ☒ Yes  
☐ No

If "No", explain the reasons why

## SIGNATURE AND DECLARATION

### Additional Comments

All photos taken have been reviewed for clarity and accuracy.

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed This On

12/19/2023



Signature of Declarant



Printed Name

Jerome Banks

Date of Inspection

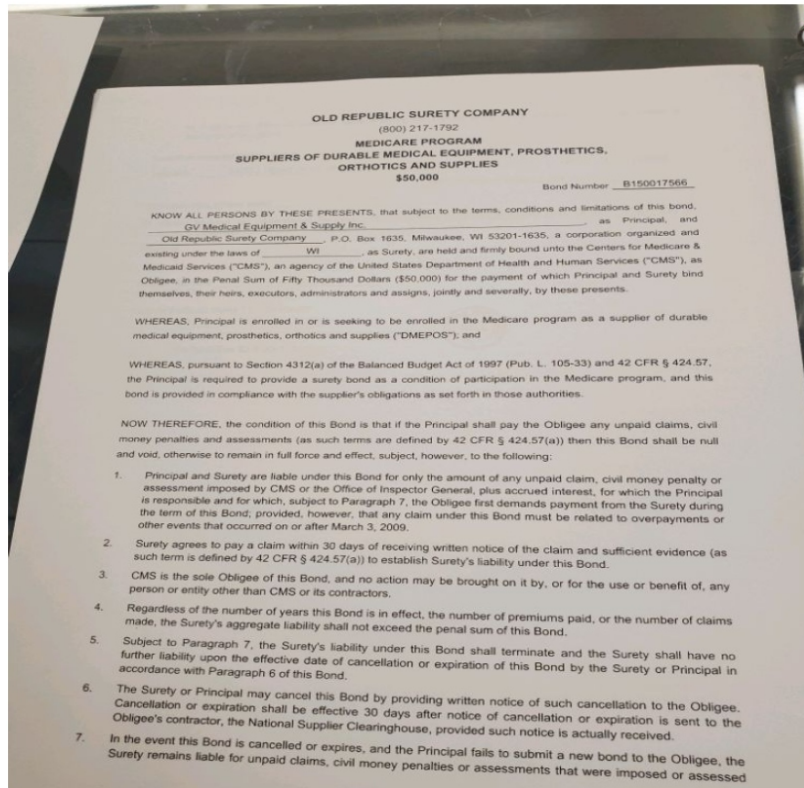
12/19/2023





Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:31 PM PST

### Address



Latitude: 33.8390699  
Longitude: -118.3531837  
Date: 12/19/2023 03:37 PM PST

### Surety Bond