Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_Diagnonsis Codes\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Need(# of Months)\_\_\_\_\_\_\_\_1-99 (99=Lifetime)

**UROLOGICAL SUPPLIES STANDARD WRITTEN ORDER**

| Catheter Type:   * Intermittent (A4351-A4352) * Foley (Indwelling) (A4311-A4316, A4338-A4346) \_\_\_\_/mo * External Male (A4326,A4349) \_\_\_\_\_Size in mm * Sterile Catheter Kit (A4353) |
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| Daily Qty: \_\_\_\_\_\_ Monthly Qty: \_\_\_\_\_\_  Tip Style:\_\_\_\_\_ Straight \_\_\_\_\_Coude  French Size:\_\_6\_\_8\_\_10\_\_12\_\_14\_\_16\_\_18\_\_20\_\_22\_\_24 |
| Monthly Supplies:   * Leg/Abdominal Drainage Bag (A4358,A5112) 2/mo * Overnight Drainage Bag (A4357) 2/mo * Sterile lubricant pack (A4332) 1 per catheter change * Insertion Tray (A4310) 1 tray per catheter change * Syringe (A4322) 4/mo |

| PROVIDER CERTIFICATION:  *I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.*  Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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