℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
UROLOGICAL SUPPLIES

Date of Last ProviderVisit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#:** **Patient DOB: / / Sex: (M/F)**

UROLOGICAL SUPPLIES

Date of Service: _____

Diagnosis and Code: _____

Length of Need (#of months):_____1-99 (99=life)

Catheter Type:

☐ Intermittent (A4351-A4353)
☐ Foley (indwelling) (A4311-A4316, A4338-A4346)
☐ External Male (A4326,A4349)_____mm

Monthly Qty: _____

French Size:

☐6 ☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20 ☐22 ☐24

Tip Style: ☐ Straight ☐ Coude

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

Medical records supports that patient has a permanent impairment (3 months or greater) of urination.

☐ Y ☐ N

There is documentation that supports the medical necessity for a coude tip catheter.

☐ Y ☐ N

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's Signature Date

_____
Provider's Name

NPI:_____Telephone: _____

Monthly Supplies:

Leg/Abdominal Drainage Bag (A4358,A5112) 2/mo
Overnight Drainage Bag (A4357) 2/mo
Non-sterile lubricant (A4402) 4.5oz/mo
Sterile lubricant pack (A4332) 1 per catheter change
Syringe(A4322) 4/mo
Sterile Water (A4217) bottle/mo
Anchoring Device (A4333) 12/mo
Insertion Tray (A4320) 1 tray per catheter change

Other Qty: _____
Other Qty: _____
Other Qty: _____
Other Qty: _____
Other Qty: _____
Other Qty: _____
Other Qty: _____
Other Qty: _____