


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
UROLOGICAL SUPPLIES**

Date of Last Provider Visit _____

<p>Supplier Name, Address, Telephone & NSC#:</p>  <p>901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1578013173</p>	<p>Patient Name, Address, Telephone & HIC#:</p> <p>() - HIC#: _____</p> <p>Patient DOB: / / Sex: (M/F)</p>
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UROLOGICAL SUPPLIES

Date of Service: _____
 Diagnosis and Code: _____
 Length of Need (#of months): _____ 1-99 (99=life)

Catheter Type:

- Intermittent (A4351-A4352)
- Intermittent with Insertion Tray (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

Monthly Supplies:

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

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: _____