℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
UROLOGICAL SUPPLIES

Date of Last ProviderVisit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
PROCARE HOME MEDICAL **915 30th Avenue Suite 106** **Fair**banks, AK **99701** **Phone: (907)** 458-8912 **Fax: (907)** 458-8914 **NSC#: 1267160002**	**(_____) - Ins ID#:** _____ **Patient DOB: / / Sex: (M/F)**

UROLOGICAL SUPPLIES

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

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 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: _____