℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
UROLOGICAL SUPPLIES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **901 N Leatherleaf Loop Suite 104.** **Wasilla, AK 99654** **Phone: (907)357-7882** **Fax: (907) 357-7883** **NSC#: 1267160003**	**( ) - 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	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: _____