


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

Date of Last Provider Visit _____

<p>Supplier Name, Address, Telephone & NSC#:</p>  <p>915 30th Avenue Suite 106 Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1124466925</p>	<p>Patient Name, Address, Telephone & HIC#:</p> <p>() - HIC#: _____</p> <p>Patient DOB: / / Sex: (M/F)</p>
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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

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) 31,000mL max/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: _____