


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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  901 N Leatherleaf Loop Wasilla, AK 99701 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	Patient Name, Address, Telephone & Insurance ID #: _____ Ins ID#: _____ Patient DOB: ____/____/____ Sex: (M/F)
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UROLOGICAL SUPPLIES

MEDICAL NECESSITY INFORMATION:

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

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

Catheter Type:

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

- Intermittent (A4351-A4352)
- Intermittent with Insertion Tray (A4353)
- Foley (indwelling) (A4311-A4316, A4338-A4346)
- External Male (A4326,A4349) _____mm

Y N

Monthly Qty: _____

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.

French Size:

Provider's Signature _____ Date _____

6 8 10 12 14 16 18 20 22 24

Provider's Name

Tip Style: Straight Coude

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: _____ |