


## UROLOGICAL SUPPLIES STANDARD WRITTEN ORDER

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| <div style="text-align: center;">  </div> <p style="text-align: center;">Please fax to:<br/> <b>Anchorage (907) 274-0773</b><br/> <b>Fairbanks (907) 458-8914</b><br/> <b>Soldotna (907) 260-3757</b><br/> <b>Wasilla (907) 357-7883</b><br/>         or email to:<br/> <b>dme@procarehm.com</b></p> | <p><b>Patient Name, Address, Telephone &amp; Insurance ID #:</b></p><br><br><p>Phone: _____ Ins ID#: _____</p> <p><b>Patient DOB:</b> _____ <b>Sex:</b> _____ <b>(M/F)</b></p> |
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Refer to the urological coverage criteria sheet for all required documentation.

### UROLOGICAL SUPPLIES

**Diagnosis and Code:**

R32 Urinary Incontinence

R33.9 Urinary Retention, Unspecified

Other: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Length of Need (#of months): \_\_\_\_\_ 1-99(99=life)

**Catheter Type:**

☐ Intermittent (A4351-A4352)

☐ Sterile Catheter Kit (A4353)

☐ Foley (Indwelling) (A4311-A4316, A4338-A4346) \_\_\_\_/mo

☐ External Male (A4326,A4349) \_\_\_\_\_ mm

**Daily Qty:** \_\_\_\_\_ **Monthly Qty:** \_\_\_\_\_

**Tip Style:** ☐ Straight ☐ Coude

French Size: ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ 20 ☐ 22 ☐ 24

**Monthly Supplies:**

Leg/Abdominal Drainage Bag (A4358,A5112) 2/mo

Other Qty: \_\_\_\_\_

Overnight Drainage Bag (A4357) 2/mo

Other Qty: \_\_\_\_\_

Sterile lubricant pack (A4332) 1 per catheter change

Other Qty: \_\_\_\_\_

Insertion Tray (A4310) 1 tray per catheter change

Other Qty: \_\_\_\_\_

Extension Tubing (A4331) 2/mo

Other Qty: \_\_\_\_\_

Syringe (A4322) 4/mo

Other Qty: \_\_\_\_\_

Anchoring Device (A4333) 12/mo

Other 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.

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ NPI: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_