INCONTINENCE SUPPLIES

Physician Detail Written Order & Certificate of Medical Necessity

HOME MEDICAL INC

P 847.480.9390 **F** 847.480.9394 **E** orders@hmedicalinc.com **W** www.hmedicalinc.com

PATIENT INFORMATION:

Name _____ Cell Phone _____ Sex: F

DOB _____ Height _____ Weight _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medicaid / Insurance Number _____

Primary Contact: Name _____ Number _____ Relationship _____

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY

Please check all boxes that apply:

- ❍ R32 Urinary Incontinence, unspecified
- ❍ N39.46 Mixed Incontinence, male, female
- ❍ N39.44 Nocturnal Enuresis
- ❍ N39.41 Urge Incontinence
- ❍ N39.42 Incontinence w/o Sensory Awareness
- ❍ N39.45 Continous Leakage
- ❍ N39.3 Stress Incontinence, male, female
- ❍ N39.40 Overflow Incontinence

Allowable: Diaper/Pull Up 200/30 days, Underpads 150/30 days, Liner 120/30 days, Gloves 2 bx/30 days

- ❍ Incontinence, adult sized diapers _____ per day _____ per month ◉ SM ❍ M ❍ LG ❍ XL ❍ XXL
- ❍ Incontinence, adult sized pull ups _____ per day _____ per month ◉ SM ❍ M ❍ LG ❍ XL ❍ XXL
- ❍ Underpads, disposable (23”x36”) _____ per day _____ per month
- ❍ Liners, disposable _____ per day _____ per month
- ❍ Gloves, bx/100 _____ per day _____ per month

REFILLS: _____

PHYSICIAN INFORMATION:

By signing below, I authorize the use of this document as a legal prescription, and certify that the above prescribed supply is medically necessary and reasonable, and this patient meets all requirements and medical necessity for above prescribed supply. Information provided is true and supported by the patient's Medical Record.

Physician Name _____ NPI# _____

Phone _____ Fax _____ Email _____

Address _____ City _____ State _____ Zip _____

Physician Signature _____ **Date** _____

Note: Please maintain a copy of the WRITTEN ORDER, which must be kept on file for 7 years or longer if required by state law.