MAIL ORDER MEDICAL SUPPLIES®

PHYSICIAN ORDER FORM

Fax Form to 228.400.1304 or 877.243.5077

CLINICIANS: Please clearly document in your chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on this form is not sufficient. In the case of an audit, Medicare would look for documentation in the patient's medical record.

Jack Marquez * cell: 786-208-0110 * office: 228.334.5291 * email: Jack@moms23.com

ORDER DATE: _____

Patient name: _____

Date of birth: _____

Length of need: 99 months/Lifetime unless otherwise noted here

Primary Diagnosis:

☐ Retention of Urine R33.9 ☐ Urinary Incontinence R32

Secondary Diagnosis:

☐ Neurogenic Bladder N31.9 ☐ Urinary tract infection N39.00
☐ Stress Incontinence N39.41 ☐ Other: _____
☐ Hypertrophy (benign) of prostate N40.1

Is this diagnosis/condition expected to last more than 90 days? ☐ Yes ☐ No

INTERMITTENT CATHETERS AND SUPPLIES

Intermittent Catheters
- ☐ Straight
- ☐ Coude (select justification below)
  - ☐ BPH
  - ☐ Strictures
  - ☐ False Passage
  - ☐ Inability to pass a straight catheter
- ☐ Hydrophilic
- ☐ Sterile insertion supplies
- ☐ Closed system

Units Per Month
(Medicare allows up to 200 catheters per month)
- ☐ 1 per day/30 month
- ☐ 2 per day/60 month
- ☐ 3 per day/90 month
- ☐ 4 per day/120 month
- ☐ 5 per day/150 month
- ☐ 6 per day/180 month
- ☐ 7 per day/200 month

Other: _____

Size
- ☐ 8 french
- ☐ 10 french
- ☐ 12 french
- ☐ 14 french
- ☐ 16 french
- ☐ 18 french
- ☐ 20 french

Other: _____

Length
- ☐ 6″
- ☐ 10″
- ☐ 16″

Lubricant

Sterile Packets
(Medicare allows 1 per catheterization)
- ☐ 1 per catheter

Tubes
(Medicare allows 2 per month)
- ☐ 1 per month
- ☐ 2 per month

Foley Catheter
(Medicare allows 1 per month)
Qty/Month: _____
Insertion tray ☐ Yes ☐ No
Coude tip required ☐ Yes ☐ No
Silicone required ☐ Yes ☐ No

Size
☐ 14 ☐ 20
☐ 16 ☐ 22
☐ 18
Other: _____
☐ 5ml ☐ 30ml

Bed Bags
(Medicare allows 2 per month)
☐ 2

Leg Bags
(Medicare allows 2 per month)
☐ 2

Male External Catheters
(Medicare allows 35 per month)
Size: _____
- ☐ 1 per day/30 per month
- ☐ 35 per month

Notes/Other Supplies/Preferred Brand:

Prescription - Must be completed and signed by the physician, nurse practitioner, or physician assistant who is prescribing the product.

Practice name: _____ Office address: _____

Office phone: _____ Office fax: _____

Office contact: _____ Email: _____ Direct line or text: _____

Clinician name (please print): _____ NPI#: _____

Clinician's signature: _____ Date: _____

(original signature required - no stamps) *(must be dated by signator)*