OSTOMY PRESCRIPTION FORM

Advanced Care Solutions

COMPLETE MEDICAL SUPPLIES

Patient Name: _____ DOB: _____

Address: _____ Phone #: _____

City: _____ State: _____ ZIPCODE: _____

Insurance Name: _____Id # _____

DIAGNOSIS ON FILE

PRIMARY DIAGNOSIS (REQUIRED)
ICD-10 CODE: _____ CODE DESCRIPTION: _____

SECONDARY DIAGNOSIS
ICD-10 CODE: _____CODE DESCRIPTION:_____ _____

Patient's medical record supports that patient has a surgically created stoma to divert urine or fecal content outside the body and includes location, construction and condition of skin surrounding the stoma.

REFILLS: ( ) 3 MONTHS ( ) 6 MONTHS ( ) 12 MONTHS START DATE: ____/____/_____

EQUIPMENT/SERVICES (Please select all that apply and provide reference numbers if available)

MANUFACTURER ( ) Hollister ( ) Convatec ( ) Genairex ( ) Other: _____

Pouch/Bags
( ) 20 ea Ostomy Drainable Pouch ( ) One piece system ( ) Two piece System
BRAND _____ REFERENCE # _____
( ) 60 ea Ostomy Closed Pouch ( ) One piece system ( ) Two Piece System
BRAND _____ REFERENCE # _____

Wafers/Flange
( ) 20 ea Ostomy Wafers **BRAND_____ REFERENCE # _____**

Accessories (please check all that apply)
( ) 1bx Skin Prep Barrier Wipes (25 UNITS) ( ) 1bx Adhesive Remover wipes (50 UNITS)
( ) 2ea Ostomy Paste 2oz each (8 UNITS) 20ea ( ) Ostomy Seals ( ) Ostomy Strips
( ) 1 Bottle of Deodorant 8oz (8 UNITS) ( ) 40 units of tape any size
( ) 1 ea Ostomy Powder (1 UNIT)
OTHER: _____

PHYSICIAN ATTESTATION I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness**. The patient and or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other Insurance for post payment review or audits.

PHYSICIAN NAME: _____ NPI # _____PHONE # _____

PHYSICIAN SIGNATURE_____ DATE_____

ADVANCED CARE SOLUTIONS - PHONE: (877) 748-1977; FAX: 877-748-1985

COMPLETE MEDICAL SUPPLIES - PHONE: (866) 748-5151; FAX: 866-634-8166