OSTOMY PRESCRIPTION FORM

Patient Name: _____ DOB_____

START DATE: _____ REFILLS: (X) LIFETIME ( ) OTHER: _____/months

If patient has 2 stomas please initial _____ (Medical Record must have noted that two stomas are present and their corresponding ICD10 DX for coverage. Selection will double quantity of supplies below.)

Pouch/ Bags
(X) 20 ea Ostomy Drainable Pouch (X) 60 ea Ostomy Closed end Pouch

Wafers/Flange
(X) 20 ea Ostomy Wafers

Anything over the allowable will need additional medical records for Medicare patients and an Authorization plus additional records for all Health Plans. Please su

Other: (Additional qty needed for coverage): _____

Accessories: Patient qualifies for the following items. Continued need & use will be verified monthly.
(X) Skin Prep Wipes or spray (25ea / 50ea every other month or 1btl spray monthly)
(X) Adhesive Remover wipes or spray (1bx/50ea monthly or 1btl spray monthly)
(X) Ostomy Paste (2ea tubes monthly) (X) 31 ea stoma seal/Plug (x) Tape any size 40 units (per month)
(X) Deodorant Btl or packet (16oz per month/13units of packets (X) Ostomy Powder (1oz monthly or 3.5 oz/6mo
(X) Ostomy Seals/ Strips /Rings / Sheets or Extenders (20 units monthly per HCPC code A4385/A5121/A4362)
(X) Appliance Cleaner (16oz monthly) , (X) Ostomy belt (1ea month), (X) Ostomy Vent (60 units month)
(X) Drain Bag /Leg Bag (2 units per month of ea for **Urostomy only**) (X) Drain Bottle 2ea/6mo for **Urostomy only**

Other: (product, ref# if available and qty: _____

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 t h e patient's medical record and made available to Medicare or other Insurance for post payment review or audits.

PHYSICIAN NAME: _____ NPI # _____ PHONE # _____

Instructions for Referral Submission
Fax or email completed form along with the documents listed below

- Patient Face Sheet (containing current demographics and insurance)
- Medical Record (must include Diagnosis codes) with in last 30 days that confirms need for supplies based on condition i.e. Z93.3, Z93.2 Z93.6 or similar

PH# 866-748-5151 FAX# 866-634-8166 EMAIL: Intake@acsmedical.com

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