UROLOGICAL PRESCRIPTION FORM

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

PATIENT INFORMATION		
FIRST NAME:	**LAST NAME:**	**DOB:**
ADDRESS:	**CITY:**	**STATE / ZIP:**
PHONE:	**EMAIL:**	
PRIMARY INSURANCE:	**POLICY / ID #:**	**ORDER DATE:**
SECONDARY INSURANCE:	**POLICY / ID #:**	**REFILLS: (●) LIFETIME ( ) OTHER: mo.**

PRIMARY DIAGNOSIS — select one: ( ) R33.9 Retention of Urine ( ) R32 Urinary Incontinence ( ) Other:
SECONDARY DIAGNOSIS (if applicable):
PERMANENT CONDITION — not expected to be corrected within 3 months? ( ) YES ( ) NO **LATEX ALLERGY?** ( ) YES ( ) NO
A "No" to permanent condition means these supplies are not covered by Medicare — see page 2. If latex allergy is Yes, latex products will not be dispensed.
HOW TO COMPLETE: mark only the items prescribed. Italic quantities are the standard monthly allowable for a 30-day supply; 1-, 2- or 3-month dispensing is permitted where the plan allows.
ALL CATEGORIES REQUIRE SUPPORTING DOCUMENTATION IN THE MEDICAL RECORD — see page 2 for what is needed.

A. INTERMITTENT CATHETERS	
( )	Intermittent Urinary Catheter — straight
( )	Intermittent Urinary Catheter — Coude tip
( )	Intermittent Catheter with Insertion Supplies (sterile kit) ( ) Straight ( ) Coude tip

FRENCH SIZE — select one: ( ) 8 FR ( ) 10 FR ( ) 12 FR ( ) 14 FR ( ) 16 FR ( ) Other:
FREQUENCY PER DAY (required) — select one: ( ) 2 / day = 60 per month ( ) 3 / day = 90 per month
( ) 4 / day = 120 per month ( ) 5 / day = 150 per month ( ) 6 / day = 180 per month ( ) Other:

ORDER	ITEM	SIZE	QTY / MONTH
B. INDWELLING (FOLEY) CATHETERS AND INSERTION TRAYS			
( )	Foley Catheter — *allowable 1 / month* ( ) Two-way ( ) Three-way ( ) Latex ( ) Silicone	FR	
( )	Foley Insertion Tray — *allowable 1 / month* ( ) With bag ( ) Without bag	cc	
C. EXTERNAL CATHETERS			
( )	Male External Catheter — *allowable 35 / month*	mm	
D. DRAINAGE BAGS AND BOTTLES			
( )	Bedside Drainage Bag — *allowable 2 / month*	—	
( )	Leg Bag — *either vinyl or latex, not both* ( ) Vinyl — allowable 2 / month ( ) Latex — allowable 1 / month	—	
( )	Drainage Bottle — *allowable 1 per 3 months*	—	
E. ACCESSORIES			
( )	Sterile Lubricant Packets — *allowable 200 / month — one per catheterization*	—	
( )	Lubricant, Tube — *billed per ounce — enter quantity in oz*	—	
( )	Catheter Anchoring Device, adhesive — *allowable 3 / week*	—	
( )	Catheter Leg Strap — *allowable 1 / month*	—	

F. OTHER ITEMS AND QUANTITIES ABOVE THE ALLOWABLE
Other (item, description, quantity):
Clinical reason / non-routine basis:
Quantity exceeding standard allowable (item and quantity):
Brand preference, if any (optional):
Products are dispensed per the patient's health plan formulary and contracted availability. Equivalent product substitution may occur.

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 the 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:		

Please submit the following with Signed Order
( ) Patient Face Sheet — current demographics and insurance
( ) Chart notes supporting the diagnosis and showing the condition is permanent. *(see page 2 for additional criteria)*
Most recent notes, no older than 12 months.

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DOCUMENTATION GUIDE FOR THE ORDERING PRACTITIONER

Reference only — not part of the order. Do not return this page.

Medical necessity must be supported in the patient's medical record, not on the prescription. Find the row matching what you ordered. Letters match the category headings on page 1.

IF YOU ORDERED	THE RECORD MUST SHOW
Any supply	The condition is permanent — not expected to be medically or surgically corrected within 3 months. The note that established permanence may be from any date.
A. Intermittent catheters	The patient or caregiver is able to perform the catheterization, and support for the frequency ordered.
A. Coude tip	Why a straight-tip catheter cannot be used — for example urethral stricture, false passage, prostatic enlargement obstructing passage, or documented failed attempts with a straight tip. Preference is not sufficient.
A. Sterile catheter kit	One of the following: resides in a nursing facility · is immunosuppressed (post-transplant immunosuppressive drugs, cancer chemotherapy, AIDS, chronic oral corticosteroid use, or spinal cord injury at any level) · radiologically documented vesico-ureteral reflux while on intermittent catheterization · two distinct, recurrent UTIs in the prior 12 months while on sterile intermittent catheterization. If the reason is recurrent UTI, send the supporting urine culture and lab results.*
B. More than one Foley catheter or insertion tray in a month	The reason for each additional change. One per month is covered for routine maintenance; anything beyond that is a non-routine change and must be justified — for example: catheter accidentally removed · malfunction, such as a balloon that will not stay inflated or a hole in the catheter · obstruction by encrustation, mucous plug or blood clot · established history of recurrent obstruction or UTI where a scheduled change more often than monthly prevents an acute event.
B. Specialty or all-silicone catheter	The medical need for that specific catheter — for example recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex.
C. Male external catheter	Permanent urinary incontinence, with the external catheter used as an alternative to an indwelling catheter. Over 35 per month requires documentation of medical necessity.
D. Leg bag	The patient is ambulatory, or chair or wheelchair bound.
E / F. Any quantity above the standard allowable	A Letter of Medical Necessity with supporting medical records. Most non-Medicare plans also require a letter of agreement or single-case agreement.
F. Items not listed on the order	A stated non-routine need — this includes irrigation supplies such as saline, which are not covered for routine use.

NOT COVERED

- Male external catheters, when the patient also uses an indwelling catheter.
- Leg bags for bedridden patients.
- A vinyl leg bag and a latex leg bag in the same month — payment is made for one or the other.

* A urinary tract infection means a urine culture above 10,000 colony forming units of a urinary pathogen, together with one or more of: fever above 100.4°F · systemic leukocytosis · change in urinary urgency, frequency or incontinence · new or increased autonomic dysreflexia · physical signs of prostatitis, epididymitis or orchitis · increased muscle spasms · pyuria above 5 WBCs per high-powered field.