

Referral Number: Referral Name, Address and Phone:

## Incontinence

Order Form

▶ Required Information □ Face Sheet Attached

| PATIENT INFORMATION:   |  | l i                       |                  |
|--|--|---------------------------|------------------|
| u Patient Name (Last, First): ▶Date of Birth (MM/DD/YY):   |  |                           |                  |
| ▶Street:   |  |                           |                  |
| ▶City:   |  | Zip Code:                 |                  |
| ▶Phone Number:   | Mobile Number:                             |                           |                  |
| Language: 🛛 English 🗳 Spanish 🗳 Other:   | Email:                                     |                           |                  |
| ▶Primary Insurance: ID#_   | Phone:                                     |                           |                  |
| Secondary Insurance :  |  |                           |                  |
|  |  |                           |                  |
| u Start Date: ▶Length of need: 99=Lifetime unless otherwise indicated. □ Other: Months   |  |                           |                  |
| ▶Primary Diagnosis (Cause of Incontinence): Latex Allergy? □ Yes □ No  |  |                           |                  |
| Type of Incontinence:  Permanent Urinary Incontinence R32  Mixed Incontinence N39.46   |  |                           |                  |
| Incontinence with Feces R15.9  |  |                           |                  |
| RECOMMENDED SUPPLIES:  |  |                           |                  |
| Items  | Size                                       | HCPCS Code Monthl         | v Allowable      |
| Adult Briefs (Diapers)   | Small 20" to 31"                           | T4521                     | <u> </u>         |
|  | Medium 32" to 44"                          | T4522                     |                  |
|  | Large 45" to 58"                           | T4523                     |                  |
|  | X-Lrg 59" to 64"                           | T4524                     |                  |
|  | Disposable Brief/Diaper, Bariatric         | T4543                     |                  |
| Adult Protective Underwear (Pull-Ups)  | Small 20" to 34"                           | T4525                     |                  |
|  | Medium 32" to 44"                          | T4526                     |                  |
|  | Large 44" to 58"                           | T4527                     |                  |
|  | X-Lrg 58" to 68"                           | T4528                     |                  |
| Pediatric Diapers & Pull-Ups   | Diapers (check size chart) Small & Medium  | T4529                     |                  |
|  | Diapers (check size chart) Large & X-Lrg   | T4530                     |                  |
|  | Pull-Ups (check size chart) Small & Medium | T4531                     |                  |
|  | Pull-Ups (check size chart) Large & X-Lrg  | T4532                     |                  |
| Youth Briefs (Diapers)   | Diapers (check size chart) Youth           | T4533                     |                  |
| Youth Protective Underwear (Pull-Ups)  | Pull-Ups (check size chart) Youth          | T4534                     |                  |
| Underpads  | Disposable 23" x 36"                       | A4554                     |                  |
|  |  |                           |                  |
| Bladder Control Pads   | Moderate 11"                               | A4520                     |                  |
|  | Long Max 13"                               | A4520                     |                  |
|  |  |                           |                  |
| Gloves*  | Gloves                                     | A4927                     |                  |
| *only approved for members living at home  |  |                           |                  |
| NAME, NPI#   | NAME, NPI#                                 | NAME, NPI#                |                  |
|  |  |                           |                  |
| Licensed Healthcare Provider's Acknowledgement: My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Byram Healthcare regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name. |  |                           |                  |
| ▶Licensed Healthcare<br>Provider's Signature:  |  | Dato:                     |                  |
|  | Signature stamps are NOT acceptable        | ▶Date:<br>Date stamps are | e NOT acceptable |

## For more information, please call: 1-800-364-6057

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