

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 Provider's Signature:		Dato:	
	Signature stamps are NOT acceptable	▶Date: Date stamps are	e NOT acceptable

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

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