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INCONTINENCE ORDER FORM

****Please attach face sheet w/ patient demographics & insurance info****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
 Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
 Mon Tues Wed Thur Fri Sat

DIAGNOSIS

Primary Diagnosis
 ICD-10 Code: _____

Secondary Diagnosis
 ICD-10 Code: _____

Patient Weight: _____ Patient Waist Size: _____

PRODUCT SELECTION

Products and Sizes	Quantity Per Day	Total Quantity Dispensed
Baby Briefs <input type="checkbox"/> Size 2(S) Under 16lbs <input type="checkbox"/> Size 3(M) 16-28lbs <input type="checkbox"/> Size 4(L) 22-37lbs <input type="checkbox"/> Size 5(XL) 27-35lbs <input type="checkbox"/> Size 6(XXL) 35lbs and up		
Youth Pull Ups <input type="checkbox"/> Small/Medium 38-65lbs <input type="checkbox"/> Large/X-Large 65-85lbs		
Pull Up Training Pants Girls <input type="checkbox"/> Size 2 18-34lbs <input type="checkbox"/> Size 3 34-40lbs <input type="checkbox"/> Size 4 38lbs and up		
Pull Up Training Pants Boys <input type="checkbox"/> Size 2 18-34lbs <input type="checkbox"/> Size 3 34-40lbs <input type="checkbox"/> Size 4 38lbs and up		
Liners <input type="checkbox"/> One Size		
Underpads <input type="checkbox"/> Disposable <input type="checkbox"/> Reusable		
Adult Briefs <input type="checkbox"/> Small 20-31in. waist <input type="checkbox"/> Medium 32-44in. waist <input type="checkbox"/> Large 45-58in. waist <input type="checkbox"/> X-Large up to 64in. waist <input type="checkbox"/> XXXLarge 60-70in. waist		
Adult Pull Ups <input type="checkbox"/> Small under 34in. waist <input type="checkbox"/> Medium 34-45in. waist <input type="checkbox"/> Large 44-54in. waist <input type="checkbox"/> X-Large 48-66 in. waist		
Other:		

Order Date: ____/____/____
 Start Date: ____/____/____

Length of Need: _____ months

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
 Office Address: _____ Email: _____
 Phone: _____ Preferred Method of Contact? Phone Fax Email
 Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____