

Patient Information

Please attach patient demographics, chart notes, and insurance card/information.

Patient Name: _____ DOB: _____

Phone: _____ Email: _____

Insurance Provider: _____ Insurance ID: _____

Diagnosis

PRIMARY	
☐	R32 Urinary Incontinence
☐	R15.9 Fecal Incontinence

SECONDARY *A secondary diagnosis that is causing the patient's incontinence is typically required by insurance.	
☐	E11.9 Diabetes Mellitus
☐	F03.90 Dementia
☐	F84.0 Autism
☐	G80.9 Cerebral Palsy
☐	F84.9 Developmental Delay
☐	N39.44 Nocturnal Enuresis
☐	Q90.9 Down Syndrome
☐	R39.81 Functional Incontinence
☐	Other:

Only Medicaid Primary or Secondary policies will typically cover incontinence supplies. Medicaid recipients under 3 years of age are NOT eligible for incontinence supplies.

Supplies

	SIZE	QTY/MO
☐ Adult Briefs/Diapers (max. 240/month)		
☐ Adult Pull-Ons (max. 240/month)		
☐ Adult Bladder Control Pads (max. 240/month)		
☐ Underpads/Chux (max. 240/month)		
☐ Children/Youth Diapers (max. 240/month)		
☐ Children/Youth Pull-Ons (max. 240/month)		
☐ Gloves (max. 2 boxes/month)		
☐ Barrier Cream – 4 oz tubes (max. 2/month)		

Order Date: _____ Start Date: _____ Length of Need: _____ months
(99 = Lifetime)

Prescriber Information

Fax order & chart notes: 866-420-7099 • Emergency orders: Call 855-937-4168

Practice Name: _____ Ordering Physician: _____

Phone: _____ Fax: _____

Prescriber Signature: _____ Date: _____