Urology Order Form (Adult)
P: 844-276-5588 • F: 800-831-2454

Aeroflow Urology

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-Ups (max. 240/month)		
☐	Adult Bladder Control Pads (max. 240/month)		
☐	Underpads/Chux (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: _____