Urology Order Form (Pediatric)
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
Children/Youth Diapers (max. 240/month)		
Children/Youth Diapers (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: ______