Fax: 866-496-7054

Phone: 866-919-1246

Email: info@aimplusonline.com

# CATHETER RX

DAW-Dispense As Written ☐

## PATIENT INFORMATION AND INSURANCE

Patient Name:______________________________

Address:______________________________

Phone: ____________________ Secondary Phone____________________

Gender: (please check) ___Male or ___Female DOB: ______________ Language: __________

Primary Insurance: ______________________________

Secondary Insurance:______________________________

## DIAGNOSIS

ICD-10:____________________Secondary DX ICD-10: ____________________

R33.9 Retention of Urine ______ R32 Urinary Incontinence ______

Number of Refills: (99=Lifetime)_____________ LATEX FREE PRODUCTS: ___YES or ___NO (please check)

**UTI History: (please check) ___YES or ___NO (If yes , please send lab and supporting documents)**

***Medicare Criteria (A4353): 2 UTI's in past 12 months.**

****MEDICAL JUSTIFICATION REQUIRED FOR USING A COUDE CATHETER. Medicare criteria (A4352) (not limited to):**

**___The patient's anatomy is such that a straight tip catheter is ineffective in passing through the urethra, and a curve tip catheter is required to conform to the patient's anatomy.**

**___The patient has an enlarged prostate gland, which creates an obstruction that requires a coude tipped catheter.**

**___The patient has a Koch or Indiana pouch which requires a Coude tipped catheter for drainage.**

**Other ______________________________**

**UROLOGICAL PRODUCTS** **Manufacturer: ____________________ (If not specified, CURE will be dispensed.)

| PRODUCT DETAILS | QUANTITY/DAY | QUANTITY/MO | FR SIZE |
|---|---|---|---|
| Intermittent Cath (A4351) | | | |
| Sterile Intermittent Cath w/ Insertion Supplies* (A4353) | | | |
| Intermittent Coude Cath** (A4352) | | | |
| Intermittent Hydrophilic Cath | | | |
| External Cath | | | |
| ___Foley Cath ___ Insertion Tray (please check all that apply) | | | |
| __Bedside Drainage Bag __ Leg Bag __ Leg Strap (please check all that apply) | | | |
| Irrigation Tray* | | | |
| Lubricant: ___Individual Packets ___ Tube (please check one) | | | |
| Other: | | | |
| Details on above item (s): | | | |

**Physician Name (PRINT):____________________ NPI:____________________**

**Physician Signature (NO STAMPS): ____________________ Date:______________**

**Physician Phone:____________________ Physician Fax:____________________**

I CERTIFY THAT THIS ORDER IS RESONABLE AND MEDICALLY NECESSARY AND NOT MERELY A CONVENIENCE ITEM OR IT IS A MANDATED BENEFIT. This document may serve as a confirmation as a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete, I understand that any falsification, omission or concealment of material fact may subject me to a civil or criminal liability. RETAIN COPY IN PATIENT'S CHART.