



### Step 1: Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  Male  Female  
**NOTE: Please include patient face sheet** POA Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Step 2: Facility Information

Facility Name: \_\_\_\_\_ Facility Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

### Step 3: Insurance Information

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
 Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_ Policy/ID Number: \_\_\_\_\_

### Step 4: Doctor Information

Primary Doctor Name: \_\_\_\_\_ Primary Doctor Address: \_\_\_\_\_  
 Primary Doctor Phone Number: \_\_\_\_\_ Primary Doctor Fax Number: \_\_\_\_\_  
 Urologist Name: \_\_\_\_\_ Urologist Address: \_\_\_\_\_  
 Urologist Phone Number: \_\_\_\_\_ Urologist Fax Number: \_\_\_\_\_

### Step 5: Recommended Supplies

Straight Intermittent Catheters	Brand/Item	French Size/Length	Frequency of Use	Quantity
Intermittent Urinary Catheter Straight Tip (up to 200/mo)		<input type="checkbox"/> 8 FR <input type="checkbox"/> 10 FR <input type="checkbox"/> 12 FR <input type="checkbox"/> 14 FR <input type="checkbox"/> 16 FR <input type="checkbox"/> 18 FR <input type="checkbox"/> Male: 16" <input type="checkbox"/> Female: 6"	<input type="checkbox"/> 2/day or 60/mo <input type="checkbox"/> 3/day or 90/mo <input type="checkbox"/> 4/day or 120/mo <input type="checkbox"/> 5/day or 150/mo <input type="checkbox"/> 6/day or 180/mo Other: _____	
Intermittent Urinary Catheter: Coude Tip (up to 200/mo) <b>Note: Coude tip requires additional documentation</b>		<input type="checkbox"/> 8 FR <input type="checkbox"/> 10 FR <input type="checkbox"/> 12 FR <input type="checkbox"/> 14 FR <input type="checkbox"/> 16 FR <input type="checkbox"/> 18 FR <input type="checkbox"/> Male: 16"	<input type="checkbox"/> 2/day or 60/mo <input type="checkbox"/> 3/day or 90/mo <input type="checkbox"/> 4/day or 120/mo <input type="checkbox"/> 5/day or 150/mo <input type="checkbox"/> 6/day or 180/mo Other: _____	
Indwelling Catheters	Brand/Item	French Size/Length	Frequency of Use	Quantity
Foley Catheter (1/mo) <input type="checkbox"/> Standard latex w/coating <input type="checkbox"/> 100% silicone		<input type="checkbox"/> 14 FR 5cc <input type="checkbox"/> 14 FR 30cc <input type="checkbox"/> 16 FR 5cc <input type="checkbox"/> 14 FR 30cc <input type="checkbox"/> 18 FR 5cc <input type="checkbox"/> 14 FR 30cc <input type="checkbox"/> 20 FR 5cc <input type="checkbox"/> 14 FR 30cc <input type="checkbox"/> 22 FR 5cc <input type="checkbox"/> 14 FR 30cc <input type="checkbox"/> 24 FR 5cc <input type="checkbox"/> 14 FR 30cc		
Foley Catheter Insertion Tray (up to 1/mo) <b>Note: Required to be sent with Foley Catheters</b>				

Male External Catheters	Brand/Item	French Size/Length	Frequency of Use	Quantity
Male Catheter (up to 35/mo) <input type="checkbox"/> Latex		<input type="checkbox"/> 23mm <input type="checkbox"/> 28mm <input type="checkbox"/> 31mm <input type="checkbox"/> 35mm		
Male Catheter (up to 35/mo) <input type="checkbox"/> Latex-free, no aloe		<input type="checkbox"/> 25mm <input type="checkbox"/> 29mm <input type="checkbox"/> 32mm <input type="checkbox"/> 36mm <input type="checkbox"/> 41mm		
Male Catheter (up to 35/mo) <input type="checkbox"/> Latex-free, w/ aloe		<input type="checkbox"/> 23mm <input type="checkbox"/> 28mm <input type="checkbox"/> 31mm <input type="checkbox"/> 35mm <input type="checkbox"/> 40mm		
Urinary Drainage Collection Systems	Brand/Item	French Size/Length	Frequency of Use	Quantity
<input type="checkbox"/> Urinary Leg Bag, 19oz (up to 2/mo) <input type="checkbox"/> Bedside Drainage Bag, 2000ml (up to 2/mo) <b>Note: May choose up to 2 of each</b>				
Miscellaneous Supplies	Brand/Item	French Size/Length	Frequency of Use	Quantity
Lubricant <input type="checkbox"/> Packets (1/packet per catheter) <input type="checkbox"/> Tube				
Anchoring <input type="checkbox"/> Foley Anchoring Device (up to 12/mo) <input type="checkbox"/> Foley Leg Strap (up to 1/mo) <b>Note: Only 1 type of anchor can be sent monthly</b>				

**Note: There may be an out-of-pocket expense of up to 20% of services if the customer does not have a secondary coverage in addition to Medicare coverage. DME supplies covered by Medicare are subject to the annual Medicare Part B deductible.**

Signature: \_\_\_\_\_

*Caregiver Certification: I Certify That the Items Ordered are Medically Necessary, & I am Authorized to Place Orders for the Person Listed as "Customer." After Signature, Printed Name & Date.*

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