Fax: 1-800-604-9760
Phone: 1-800-441-8809

CATHETER SUPPLY ORDER

PLEASE FAX TO 1-800-604-9760

Patient:

Dear DR.

Your patient recently ordered ostomy supplies through our mail order program. In order to dispense their supplies, we must obtain a written Physician Order and supportive documentation.

Please Note:

1. Complete the attached Physician Order and fax it back to us at 1-800-604-9760
2. Medicare guidelines require that the patient's progress notes be consistent with this Physician Order, and include: (a) frequency of use and (b) diagnosis. Please verify that the patient's progress notes meet these requirements and amend, if necessary
3. Any changes to the Physician Order must be initialed and dated by the prescriber
4. Completion of prescription requires:
   - (i) Indication of Diagnosis Code(s)
   - (ii) Prescriber's Signature (No Stamp)
   - (iii) Date (No Stamp)

We will take great care of your patient! Our friendly customer service representatives communicate regularly with your patient to ensure they know how to use their supplies, answer their questions, and to assist them with convenient refills. We keep it simple by calling before we send an order, sending only items that both the physician and patient authorize, submitting all insurance claims, and shipping the order directly to their door for free.

Thank you kindly for your assistance in best serving your patient.

Sincerely,
Comfort Medical

Fax: 1-800-604-9760
Phone: 1-800-441-8809

CATHETER SUPPLY ORDER

Please review all sections and fax it back to us

PATIENT INFORMATION			
Name:		Telephone:	
DOB:	Zip:	Patient ID:	Start Date:

PRESCRIBER INFORMATION			
Name:		Telephone:	Zip:
NPI:	Fax:	Physician ID:	

PATIENT SUPPLIES REQUESTED

	HCPCS	Description	Frequency	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Authorizing 99 refills. If otherwise, please specify: _____. (Cannot be PRN.)

The above information is true, accurate, and complete to the best of my knowledge. I confirm that the patient is/was treated by me, and is able to use the supplies prescribed. I verify that the patient's medical condition requires the supplies prescribed, and that the usage quantities are medically necessary. I will maintain a copy of this order in the patient's file.

IMPORTANT: PATIENT DIAGNOSIS

1. Patient has permanent urinary retention and/or incontinence?

☐ Retention **(R33.9)** ☐ Incontinence **(R32)**

2. Patient has experienced more than one UTI in the past 12 months?

☐ Yes ☐ No

☐ N32.9 Bladder Disorder
☐ N32.0 Bladder Neck Obstruction
☐ Q05.8 Sacral Spina Bifida
☐ N31.9 Neuromuscular dysfunction
☐ N35.9 Urethral Stricture (unspecified)
☐ N13.9 Obstructive and reflux uropathy
☐ N40.1 Enlarged Prostate w/ lower urinary tract symptoms
☐ Other:_____

IMPORTANT: Handwritten or Certified Electronic Signature Only

PRESCRIBER'S SIGNATURE (NO STAMPS)	DATE (NO STAMPS)
	DATE (NO STAMPS)