



PHONE: 1.888.248.1975 FAX: 1.888.248.2026

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CONTINUUM CONNECT OSTOMY ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Is the patient currently being seen by home health? Yes No Is the patient currently using Nutritional Supplements? Yes No
Language Pref.: English Spanish Other: _____
Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis

ICD-10 Code: _____

**Code must state the specific type of ostomy.

Secondary Diagnosis

ICD-10 Code: _____

**Code must state the specific type of ostomy.

TYPE OF OSTOMY

Colostomy

Ileostomy

Urostomy

PRODUCT SELECTION

Check all products that apply

1 Piece Pouch Closed Drainable
2 Piece Pouch Closed Drainable
Wafer (for 2 Piece Pouch) Flat Convex Stoma Size: _____

Quantity

Item #

ACCESSORIES SELECTION

Quantity

Bedside Urinary Drainage Bag 2000 ml
Belt (Securi-T and Convatec): One Size
Belt (Hollister): Medium Large
Barrier Ring 2" 4"
Stoma Paste Securi-T Convatec
Skin Prep Wipes One Box
Barrier Strips One Box
Deodorant 8 oz Bottle
Adhesive Remover Wipes One Box
Waterproof Tape: 1" 2" 4"
Other: _____

Length of Need: _____ months

Dispense Amount (select one): 30-day 90-day

Has the patient been educated on how to apply the system? YES NO

*The Medicare allowable is 20 Drainable Pouches or 60 Closed Pouches a month.

*The Medicare allowable is 20 Wafers a month.

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____)____-____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____