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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: \_\_\_\_\_

DIAGNOSIS

Primary Diagnosis ICD-10 Code: \_\_\_\_\_ Secondary Diagnosis ICD-10 Code: \_\_\_\_\_
\*\*Code must state the specific type of ostomy.

TYPE OF OSTOMY

MANUFACTURER

Colostomy  Ileostomy  Urostomy  Hollister  Convatec  Securi-T USA

PRODUCT SELECTION

Check all products that apply

Quantity

Item #

1 Piece Pouch  Closed  Drainable
2 Piece Pouch  Closed  Drainable
Wafer (for 2 Piece Pouch)  Flat  Convex Stoma Size: \_\_\_\_\_
Bedside Urinary Drainage Bag  One Size
Belt (Securi-T and Convatec):  One Size Belt (Hollister):  Medium  Large

ACCESSORIES SELECTION (only Securi-T accessories unless noted)

Barrier Ring  2"  4"
Stoma Paste  Securi-T  Convatec
Skin Prep Wipes  One Size
Barrier Strips  One Size
Deodorant  8 oz Bottle
Adhesive Remover Wipes (box of 50)  One Size
Tape:  1"  2"  3"
 Plastic (waterproof)  Cloth (waterproof)  Paper
Medipore:  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: \_\_\_\_/\_\_\_\_/\_\_\_\_