PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

INCONTINENCE ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______/______/__________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: __________________

Patient cannot accept deliveries on the following days?
Mon Tues Wed Thur Fri Sat

DIAGNOSIS

Primary Diagnosis
ICD-10 Code: ______________________

Secondary Diagnosis
ICD-10 Code: ______________________

Patient Weight: ______________________ Patient Waist Size: ______________________

PRODUCT SELECTION

Products and Sizes	Quantity Per Day	Total Quanity Dispensed
Baby Briefs: ☐ Size 2 Under 18lbs ☐ Size 3 16-28lbs ☐ Size 4 22-35lbs ☐ Size 5 27-35lbs ☐ Size 6 35-45lbs ☐ Size 7 41lbs and over		
Baby Pull Up Training Pants Girls: ☐ Size 2 Under 34lbs ☐ Size 3 32-40lbs ☐ Size 4 38lbs and up		
Baby Pull Up Training Pants Boys: ☐ Size 2 Under 34lbs ☐ Size 3 32-40lbs ☐ Size 4 38lbs and up		
Youth Pull Ups: ☐ Small/Medium 38-65lbs ☐ Large/X-Large 65-125lbs		
Youth Briefs: ☐ Small 20-31in. waist		
Adult Briefs: ☐ Small 20-31in. waist ☐ Medium 32-44in. waist ☐ Large 45-58in. waist ☐ X-Large up to 64in. waist ☐ XXLarge 60-70in. waist		
Adult Pull Ups: ☐ Small under 34in. waist ☐ Medium 34-45in. waist ☐ Large 44-54in. waist ☐ X-Large 48-66in. waist ☐ XXL* 60-80in. waist		
Liners: ☐ Regular ☐ Super		
Underpads: ☐ Disposable ☐ Reusable		
Other:		

Order Date: _____/______/______ **Length of Need:** __________ **months**

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: _______/_______/__________

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*All sizes may not be covered by insurances