



# Burmans

a CHC Solutions Company

PHONE: 1.844.800.5777 FAX: 1.844.800.5770

EMAIL: orders@burmansmedical.com

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_