bioCARE
a CHC Solutions Company

PHONE: 1.800.220.5246 FAX: 1.844.317.9378
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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: _____

Emergency Contact Name/Phone Number: _____

DIAGNOSIS

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

TYPE OF OSTOMY

☐ **Colostomy** ☐ **Ileostomy** ☐ **Urostomy**

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:_____	

ACCESSORIES SELECTION

		Quantity
Bedside Urinary Drainage Bag	☐ 2000 ml	
Belt (Securi-T and Convatec):	☐ One Size	
Belt (Hollister):	☐ Medium ☐ Large	
Belt (Coloplast):	☐ Standard (41") ☐ XX-Large (61")	
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: _____/_____/_____