

****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: _____	Secondary Diagnosis ICD-10 Code: _____
<small>**Code must state the specific type of ostomy.</small>	<small>**Code must state the specific type of ostomy.</small>

TYPE OF OSTOMY

Colostomy Ileostomy Urostomy

PRODUCT SELECTION

Check all products that apply	Quantity	Item #
1 Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
2 Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
Wafer (for 2 Piece Pouch) <input type="checkbox"/> Flat <input type="checkbox"/> Convex Stoma Size: _____		

ACCESSORIES SELECTION

Quantity

Bedside Urinary Drainage Bag <input type="checkbox"/> 2000 ml	
Belt (Convatec): <input type="checkbox"/> One Size	
Belt (Hollister): <input type="checkbox"/> Medium <input type="checkbox"/> Large	
Belt (Coloplast): <input type="checkbox"/> Standard (41") <input type="checkbox"/> XX-Large (61")	
Barrier Ring <input type="checkbox"/> 2" <input type="checkbox"/> 4"	
Stoma Paste <input type="checkbox"/> 2 oz Tube	
Skin Prep Wipes <input type="checkbox"/> One Box	
Barrier Strips <input type="checkbox"/> One Box	
Deodorant <input type="checkbox"/> 8 oz Bottle	
Adhesive Remover Wipes <input type="checkbox"/> One Box	
Waterproof Tape: <input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 4"	
Other:	

Length of Need: _____ months	*The Medicare allowable is 20 Drainable Pouches or 60 Closed Pouches a month.
Dispense Amount (select one): <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day	
Has the patient been educated on how to apply the system? <input type="checkbox"/> YES <input type="checkbox"/> NO	*The Medicare allowable is 20 Wafers a month.

REFERRAL INFORMATION

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, 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: ____/____/____

Call 1.855.201.3724 or visit www.chcsolutions.com for additional information.