

ONE SOURCE MEDICAL SOLUTIONS, INC. UROLOGICAL SUPPLIES PHYSICIAN ORDER

Patient Information

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 DOB: _____
 Date Prescribed: _____

Ordering Physician

Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Phone: _____
 Fax Number: _____

Please Complete and Fax To:

One Source Medical Solutions Inc.
1555 W Mockingbird Ln. Suite 210
Dallas, Texas 75235
Phone: (214) 421-7000
Fax Number: (214) 421-7001

Prognosis (Circle): **Good Fair Poor**

(Intermittent Catheterization ONLY)

1. No. of Catheterization per 24 hrs: _____
 2. Does this patient have permanent urinary incontinence? (Circle): **Yes No**
 3. Does this patient have permanent urinary retention? (Circle): **Yes No**
 4. Does patient have a history of urinary tract infections? (Circle): **Yes No**
- Duration of need: _____ month(s)

ICD-10 Diagnosis(es)	Primary Diagnosis Causing Bowel/Bladder Incontinence/Retention	

Number of Refills: _____ month(s)
 Additional Comments: _____

Medicare Allowance	Accessories / HCPCS Code	Frequency of Use	Quantity Ordered Per 30 days
25 per month	Skin Barrier Wipes or Swabs (A5120)		
1 per 8 per month	Percutaneous Catheter/Tube Anchoring Device with Adhesive Skin Attachment (A5200) Stabilizer Anchor Device (A4333)		
	Leg Bag Straps, (Latex/Foam or Fabric) (A5113/A5114)		
4 oz.	Lubricant per oz (A4402)		
1 per month	Appliance Cleaner per 16 oz (A5131)		
	Appliance Deodorant (A4394)		
	Catheter Extension Tube (A4331)		
1 per 3 months	Bedside Drainage Bottle with or without Tubing (A5102)		
1 per month	Insertion Tray without drainage bag and without catheter (accessories only) (A4310)		
	Irrigation Tray with Bulb or Piston Syringe (A4320) Syringe only (A4322)		
1 per month	Insertion Tray without drainage bag and with Indwelling catheter (Latex/Silicone/2-Way/3-Way) (A4311/A4312/A4313/A4314)		
Medicare Allowance	Urinary Drainage Bags/ HCPCS Code	Frequency of Use	Quantity Ordered Per 30 days
	Urinary Suspensory with Leg Bag with or without Tube (A5105)		
2 per month	Urinary Drainage Bag, Leg or Abdomen with our without Tube (A4358)		
2 per month	Bedside Drainage Bag (A4357)		
1 per month	Insertion Tray with drainage bag and with catheter (A4354)		
Medicare Allowance	Intermittent, External or Foley Catheters / HCPCS Code	Frequency of Use (# Change per 24 hours)	Quantity Ordered Per 30 days
200 per month	Intermittent Catheters (Circle below) Hydrophilic (A4351) Straight Tip (A4351) Coude Tip (A4352)		
200 per month	Intermittent Catheter with Insertion Supplies (A4353)		
1 per Month	Foley Catheter (Circle below) 2-way Latex (A4338) 2-way All Silicone (A4344) 3-way Continuous Irrigation (A4346)		
35 per month	Male External Catheter (A4349)		

My signature below states that this patient requires urological supplies and is being treated by me. The information in this physician's order is accurate and my documentation confirms medical necessity for the products I have listed.

Physician's Signature: _____ Signature Date: _____
 NPI# _____