



Incontinence Supplies

Instructions: Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

Order Form	Referral source (i.e. physician, website)	Follow-up on order status with	Order Date
	Referral source name	Best day to follow-up	Phone
	Referral relation to patient	Best time to follow-up	Email

Patient			Physician	
Name	Marital status	Sex	Physician name	Company
BLN account-seq #	DOB	Age	Phone / Email	Fax
Bill to address	Phone / E-mail		Physician address	
City	State	Zip	City	State Zip
	County			
Emergency contact	Emergency phone	DEA #	State license #	
Relationship to patient	Emergency email	NPI #		

Products				Diagnosis	
Quantity	Adult Diapers	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large	Rx - refill #	HCPCS Code	<input type="checkbox"/> R33.9 Retention of urine, unspecified
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> R39.14 Feeling of incomplete bladder emptying
Quantity	Underpads		Rx - refill #	HCPCS Code	<input type="checkbox"/> R33.8 Other retention of urine
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> R32. Unspecified urinary incontinence
Quantity	Vinyl / Rubber Pant (each)	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large	Rx - refill #	HCPCS Code	<input type="checkbox"/> N39.41 Urge incontinence
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> Q05. Spina Bifida
Quantity	Incontinent Pad / Liners (box)		Rx - refill #	HCPCS Code	<input type="checkbox"/> G82.20 Paraplegia
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> G82.50 Quadriplegia
Quantity	<input type="checkbox"/> Drip Collector (box) <input type="checkbox"/> Skin Barrier Ointment (each)		Rx - refill #	HCPCS Code	<input type="checkbox"/> N39.0 History of UTIs
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> Other
Quantity	<input type="checkbox"/> Leg Bag (each) <input type="checkbox"/> Overnight Drainage Bag	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large	Rx - refill #	HCPCS Code	Questions
			Pay Now Need Rx Auth Req. DME Rider		Do you have allergies to products applied to the skin?
Quantity	<input type="checkbox"/> Adhesive Remover Wipes <input type="checkbox"/> Skin Prep Wipes (box)		Rx - refill #	HCPCS Code	<input type="checkbox"/> Yes. If yes, please list.
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> No
Quantity	Tape (roll)	<input type="checkbox"/> Paper <input type="checkbox"/> Cloth <input type="checkbox"/> Waterproof <input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 3"	Rx - refill #	HCPCS Code	Allergies to Latex?
			Pay Now Need Rx Auth Req. DME Rider		<input type="checkbox"/> Yes. If yes, please list.
Quantity	Gloves <input type="checkbox"/> Sterile <input type="checkbox"/> Non-Sterile <input type="checkbox"/> Vinyl <input type="checkbox"/> Latex	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large	Rx - refill #	HCPCS Code	<input type="checkbox"/> No
			Pay Now Need Rx Auth Req. DME Rider		
Quantity	NDC #, catalog # or product description		Rx - refill #	HCPCS Code	
			Pay Now Need Rx Auth Req. DME Rider		

Primary Medical Insurance		Secondary Medical Insurance	
Plan Name	Group Name	Plan Name	Group Name
ID #	Effective Date	ID #	Effective Date
Relationship to member	Member name	Relationship to member	Member name
<input type="checkbox"/> Self (check and skip section)	DOB	<input type="checkbox"/> Self (check and skip section)	DOB
<input type="checkbox"/> Spouse <input type="checkbox"/> Child	Member ID #	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	Member ID #
Primary Pharmacy Insurance		Secondary Pharmacy Insurance	
Plan Name	Group #	Plan Name	Group #
ID #	BIN #	ID #	BIN #
	PCN #		PCN #
Relationship to insured	Person Code	Relationship to insured	Person Code
<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	

For Office Use Only: Routing	Initial	Routed to	Initial	Requested to
		Order Processing <input type="checkbox"/> Pharmacy		Database Management
		Date mm / dd / yy		Date mm / dd / yy
		Documentation		Management
		Date mm / dd / yy		Date mm / dd / yy
	Insurance Verification		New Client / Group Entry	
	Date mm / dd / yy		Date mm / dd / yy	
	Shipping		Other	
	Date mm / dd / yy		Date mm / dd / yy	

For Physician Use Only: Physician Stamp

Physician Stamp:

For Physician Use Only: Prescription

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX

Dispense As Written

Dispense 1 Month Supply 3 Month Supply

Diagnosis

R33.9 Retention of urine, unspecified

R39.14 Feeling of incomplete bladder emptying

R33.8 Other retention of urine

R32. Unspecified urinary incontinence

N39.41 Urge incontinence

Q05. Spina Bifida

G82.20 Paraplegia

G82.50 Quadriplegia

N39.0 History of UTIs

Other

Questions

Do you have allergies to products applied to the skin?

Yes. If yes, please list.

No

Allergies to Latex?

Yes. If yes, please list.

No

Additional Comments

Shipping / Delivery Expedite

BLN Best Method

UPS Ground

USPS Next Day Second Day

Other _____

Ship to address Same as bill to address

Payment

Check

Mastercard Visa

American Express Discover

Name on Credit Card

Credit Card Number

Credit Card Expiration Date



Better Living Now, Inc.
185 Oser Ave.
Hauppauge, NY 11788

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1) Patient

- a) Please complete the Member section of the order form on the reverse side indicating the insurance you have that provides coverage for your Incontinence Supplies.

2) Doctor

- a) Please complete the patient information and doctor information sections.
- b) Please indicate the products you want supplied to the patient, with directions for use and quantity required;
- c) Please sign and date on the spaces provided.

3) Some Medicare Coverage Rules that should be noted:

- a) In general, Medicare does not normally provide coverage for Incontinence Care Supplies. However, State Medicaid Programs may. Please call and ask us.