## Urological 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 |

### 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

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

### Products

| Quantity | Product | Options | Rx | HCPCS Code |
|---|---|---|---|---|
| Quantity | Male External Catheter Self Adhesive | ☐ Small ☐ Medium ☐ Large ☐ X-Large | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | Intermittent Urethral Catheter (each)<br>French: | ☐ Red Rubber ☐ Plastic | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | Vinyl / Rubber Pant (each) | ☐ Small ☐ Medium ☐ Large ☐ X-Large | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | Incontinent Pad / Liners (box) | | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | ☐ Drip Collector (box) ☐ Skin Barrier Ointment (each) | | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | ☐ Leg Bag (each) ☐ Overnight Drainage Bag | ☐ Small ☐ Medium ☐ Large | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | ☐ Adhesive Remover Wipes ☐ Skin Prep Wipes (box) | | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | Normal Saline | ☐ 500 cc ☐ 1000cc | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | Tape (roll) | ☐ Paper ☐ Cloth ☐ Waterproof ☐ 1" ☐ 2" ☐ 3" | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |
| Quantity | NDC #, catalog # or product description | | Rx - refill #<br>Pay Now Need Rx Auth Req. DME Rider | HCPCS Code |

### 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

Type of Incontinence:
☐ Permanent Uriniary Retention
☐ Permanent Uriniary Incontinence

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

| Primary Medical Insurance | | Secondary Medical Insurance | |
|---|---|---|---|
| Plan Name<br>ID # | Group Name<br>Effective Date | Plan Name<br>ID # | Group Name<br>Effective Date |
| Relationship to member<br>☐ Self (check and skip section)<br>☐ Spouse ☐ Child | Member name<br>DOB<br>Member ID # | Relationship to member<br>☐ Self (check and skip section)<br>☐ Spouse ☐ Child | Member name<br>DOB<br>Member ID # |

| Primary Pharmacy Insurance | | Secondary Pharmacy Insurance | |
|---|---|---|---|
| Plan Name<br>ID # | Group #<br>BIN #<br>PCN # | Plan Name<br>ID # | Group #<br>BIN #<br>PCN # |
| Relationship to insured<br>☐ Member ☐ Spouse ☐ Child | Person Code | Relationship to insured<br>☐ Member ☐ Spouse ☐ Child | Person Code |

### 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

Credt Card Expiration Date

For Office Use Only: Routing

| Initial | Routed to | Initial | Requested to |
|---|---|---|---|
| | Order Processing ☐ Pharmacy<br>Date mm / dd / yy | | Database Management<br>Date mm / dd / yy |
| | Documentation<br>Date mm / dd / yy | | Management<br>Date mm / dd / yy |
| | Insurance Verification<br>Date mm / dd / yy | | New Client / Group Entry<br>Date mm / dd / yy |
| | Shipping<br>Date mm / dd / yy | | Other<br>Date mm / dd / yy |

For Office Use Only: Notes

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

**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.**

**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 Urological 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.