

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information Phone: _____
 Name: _____ Date of birth: _____ Age: _____
 Medicaid ID: _____ Height: _____ Weight _____
 Recipient's Address _____

Prescribing Provider:
 Prescriber's Name: _____ Phone #: _____
 Address: _____ Fax # _____

> Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD-10 CM code):
 Primary: _____ Secondary: _____
> Specify Urine/Fecal incontinence diagnoses (Specify ICD-10 CM code):
 Primary: _____ Secondary: _____
> Mobility
 Ambulatory Minimal assistance ambulating
 Transfer Assistance Confined to bed or chair

> Extraordinary Needs - if you are requesting more than 8 per day ONLY
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

> Mental Status/Level of Orientation **Frequency of anticipated change**
 Has the ability to communicate needs During Day time (6 AM-10PM) _____
 Sometimes communicates needs During Night time (10PM – 6 AM) _____
 Unable to communicate needs

> Additional supporting Diagnoses (Specific ICD-10-CM Code) **Indicate current supportive services**
 _____ Home Health
 _____ Skilled Nursing Services
 Personal Care Services
 Other _____

> List any medications and/or nutritional therapy that would increase urine or fecal output:

> Specify incontinence supply, size, quantity/24 hours and duration of need:

	Qty per day	Size (S, M, L, XL)
<input type="checkbox"/> Diapers (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____
<input type="checkbox"/> Pull-ups (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____
<input type="checkbox"/> Liner/shield (Check one): <input type="checkbox"/> child size <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized	_____	_____

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

Date:

> Comments

 Additional documentation attached