Phone: 877-670-1120 Fax: 877-335-0356
www.tmscares.com
afechtelkotter@tmscares.com

Referral Source: ______________________
Referral Phone: ______________________

Representative: Amy Fechtelkotter

Effective Date:

PATIENT INFORMATION

☐ MALE ☐ FEMALE ▶ HEIGHT:__________ ▶ WEIGHT: __________

NAME (LAST, FIRST): ______________________________ DOB: ______________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP:________

PHONE: ______________ CONTACT: ______________ ALT PHONE: ______________

INSURANCE INFORMATION

INSURANCE:______________________ ID:______________________

INSURANCE:______________________ ID:______________________

INCONTINENCE SUPPLIES MQMB ONLY

☐ **Diapers** ☐ **Pull Ups** ☐ **Shields** ☐ **Underpads** ☐ **Wipes**

DISPENSE PER DAY: ______ X'S Waist: __________

☐ R32 – Urinary Incontinence
☐ G80.9 – Cerebral Palsy
☐ R62.50 - Developmental Delay
☐ Q90.9 – Downs Syndrome
☐ F98.0 - Enuresis
☐ F98.1 – Encopresis
☐ OTHER ______________________________

DIABETES TESTING SUPPLIES

☐ **Meter** ☐ **Lancets** ☐ **Control Solution**
☐ **Strips** ☐ **Device** ☐ **Alcohol Prep Pads**

Insulin Injecting: ☐ **Yes** ☐ **No**

TESTING TIMES PER DAY: ☐ **1X** ☐ **2X** ☐ **3X** ☐ **4X** ☐ **____X**

☐ Type I – E10.9
☐ Type II – E11.9
☐ Gestational DM – O99.810
☐ Other:

UROLOGICAL SUPPLIES

☐ **INTERMITTENT CATHETERS: ** If ordering coude tip (A4352) or catheter kits with insertion supplies (A4353), please attach medical records stating why the patient is unable to catheterize using a regular straight tip catheter ****

☐ **Straight Tip Catheter (A4351)** ☐ **Coude Tip Catheter (A4352)** ☐ **Catheter with Insertion Supplies (A4353)**

DISPENSE: ☐ 6X Daily ☐ 5X Daily ☐ 4X Daily ☐ 3X Daily ☐ Other: ___X Daily ☐ Other: ________________

☐ Lubricant
☐ Extension Tubing
☐ Leg Bags (2/Mth)
☐ Male External Catheter (35/Month)
☐ Bedside Drainage Bag (2/Month)
☐ Drainage Bottle (1 Every 3 Months)
☐ Foley Catheter (1-2/Month)
☐ Catheter Straps (8/Month)
☐ Appliance Cleaner (16 oz/mth)
☐ Tape (2 Rolls/Month)
☐ Leg Bag Straps (1 Pair/Month)
☐ OTHER: ______________

DIAGNOSIS: ☐ R33.9 Urinary Retention ☐ N31.9 Neurogenic Bladder ☐ N13.9 Urinary Obstruction
☐ N35.9 Urethral Stricture ☐ Other: ______________________________

PHYSICIAN INFORMATION

LENGTH OF NEED: 6 Months or _________ DATE LAST SEEN: ______________
(6 months unless otherwise specified)

NAME (LAST, FIRST):______________________ PHONE: ______________ FAX: ______________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: __________

BY SIGNING BELOW, I AM STATING THAT: I am or was this patient's treating physician during the order period. This order accurately reflects the patient's condition, my prescription for above prescribed, and is substantiated by medical records. I have seen this patient within the last 6 (six) months to evaluate their condition. The patient or their caregiver is adequately trained to be able to operate/use the prescribed equipment and/or supplies. **I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

X______________________________ Date__________ NPI # ______________
PHYSICIAN'S SIGNATURE (NO STAMPED SIGNATURES)