



HOME

medical  
SUPPLY

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<input type="checkbox"/> NC Medicaid	<input type="checkbox"/> Alliance	<input type="checkbox"/> Trillium/CC
<input type="checkbox"/> Amerihealth	<input type="checkbox"/> VayaHealth	<input type="checkbox"/> Other:
<input type="checkbox"/> WellCare	<input type="checkbox"/> Partners/CC	<input type="checkbox"/> Healthy Blue
<input type="checkbox"/> UHC	<input type="checkbox"/> Carolina Complete	

## Incontinence Supplies Order Form

### PATIENT INFORMATION -

Patient Name: \_\_\_\_\_

Medicaid ID# \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

\*\*Please attach facesheet w/patient demographics &amp; insurance info\*\*

\*\*Please attach lab work, clinical notes and/or any other relevant documentation\*\*

### PRIMARY DIAGNOSIS

<input type="checkbox"/> R32 Urinary Incontinence
<input type="checkbox"/> R15.9 Fecal Incontinence

NC Medicaid Primary or Secondary policies will typically cover incontinence supplies. Medicaid recipients under 3 years of age are NOT eligible for incontinence supplies.

### BRIEFS/DIAPERS (max. 192-200/month) specify

<input type="checkbox"/> T4521 SMALL 20"-33"
<input type="checkbox"/> T4522 MEDIUM 32"-42"
<input type="checkbox"/> T4522 REGULAR 40"-50"
<input type="checkbox"/> T4523 LARGE 48"-58"
<input type="checkbox"/> T4524 XLARGE 57-66"
<input type="checkbox"/> T4543 XXLARGE 60"-69"

### PULL UPS (max. 192-200/month) specify

<input type="checkbox"/> T4525 SMALL 20"-28"
<input type="checkbox"/> T4526 MEDIUM 28"-40"
<input type="checkbox"/> T4527 LARGE 40"-56"
<input type="checkbox"/> T4528 XLARGE 56"-68"
<input type="checkbox"/> T4544 XXLARGE 68"-80"

### SECONDARY \*A secondary diagnosis that contributes to the patient's incontinence is typically required

<input type="checkbox"/> F84.0 Autism	<input type="checkbox"/> F84.9 Developmental Delay
<input type="checkbox"/> G80.9 Cerebral Palsy	<input type="checkbox"/> Q90.9 Down Syndrome
<input type="checkbox"/> F03.90 Dementia	<input type="checkbox"/> R39.81 Functional Incontinence
<input type="checkbox"/> E11.9 Diabetes Mellitus	<input type="checkbox"/> N39.44 Nocturnal Enuresis
<input type="checkbox"/> Other: _____	

### PEDS & YOUTH (max. 192-200/month) specify

<input type="checkbox"/> T4529 Diaper S & M
<input type="checkbox"/> T4530 Diaper Lg & X-Lg
<input type="checkbox"/> T4531 Pull-Ups S & M
<input type="checkbox"/> T4532 Pull-Ups Lg & X-Lg
<input type="checkbox"/> T4533 Diapers Youth
<input type="checkbox"/> T4534 Pull-Ups Youth

### miscellaneous continence products

<input type="checkbox"/> A4927 GLOVES 100 per bx	max 4/mo
<input type="checkbox"/> A4554 UNDERPADS/CHUX	max 150/mo
<input type="checkbox"/> A4335 MISC INCONTINENCE	

Other DME Orders: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_ Length of need (99mon = Lifetime) \_\_\_\_\_

### ORDERING PROVIDER INFORMATION Practice Address \_\_\_\_\_

Physician Name: _____	NPI: _____
Physician Signature: _____	Date: _____
Physician Phone #: _____	Fax #: _____

\*\*\*Signature and/or Date stamps are not acceptable and will not qualify\*\*\*