Medline Incontinence Supply Order Form

Medline Industries Inc.
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Please fax to: 866-202-1563 or Email:managedcarefax@medline.com

PATIENT'S INFORMATION

FIRST NAME_____LAST_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____DOB_____

SEX OF PATIENT: ❑ MALE ❑ FEMALE

E-MAIL_____

ICD-10 CODE/DIAGNOSIS_____

HEIGHT_____WEIGHT_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____

PRIMARY INSURANCE POLICY NUMBER_____

SECONDARY INSURANCE_____

SECONDARY INSURANCE POLICY NUMBER_____

POLICY HOLDER FIRST NAME_____LAST_____

POLICY HOLDER RELATION TO PATIENT: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ PARENT

PHYSICIAN FIRST NAME_____LAST NAME_____

PHYSICIAN PHONE_____FAX_____

NPI # ----------

REFERRED BY: _____ NAME OF ORDERING CONTACT_____ORDERING CONTACT PHONE_____

ORDERING CONTACT E-MAIL_____

START DATE_____ DURATION OF NEED: 12 MONTHS FREQUENCY OF USE: MONTHLY

PATIENT INFORMATION (CHECK ONLY IF APPLICABLE): TUBE-FED ❑ DIABETIC ❑ NON-AMBULATORY ❑ ON A DIURETIC ❑

BRIEFS			
HCPCS	ITEM	SIZE (WAIST SIZE)	QUANTITY PER MONTH (EA)
T4521	SMALL BRIEF	SMALL 20"-33"	
T4522	MEDIUM BRIEF	MEDIUM 32"-42"	
T4522	REGULAR BRIEF	REGULAR 40"-50"	
T4523	LARGE BRIEF	LARGE 48"–58"	
T4524	EXTRA LARGE BRIEF	XLARGE 57-66"	
T4543	XXL BRIEF	XXLARGE 60"-69"	

PULL UPS			
HCPCS	ITEM	SIZE (WAIST SIZE)	QUANTITY PER MONTH (EA)
T4525	PROTECTIVE UNDERWEAR SM	SMALL 20"-28"	
T4526	PROTECTIVE UNDERWEAR MD	MEDIUM 28"-40"	
T4527	PROTECTIVE UNDERWEAR LG	LARGE 40"-56"	
T4528	PROTECTIVE UNDERWEAR XL	XLARGE 56"-68"	
T4544	PROTECTIVE UNDERWEAR XXL	XXLARGE 68"-80"	

LINERS			
HCPCS	ITEM	SIZE	QUANTITY PER MONTH (EA)
T4535	CAPRI LINER	2.75" X 9.75"	
T4535	CAPRI LINER	3" X 10.5"	
T4535	CAPRI LINER	3.25" X 13"	
T4535	CAPRI LINER	5.5" X 10.5"	
T4535	CAPRI LINER	6.5" X 13.5"	
T4535	CAPRI LINER	7" X 17"	

WRITE IN			
HCPCS	ITEM	SIZE	QUANTITY PER MONTH (EA)

ORDERING PROVIDER

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed copy of this order in my medical records.

(Please Print)

Ordering Physician or License Prescriber: _____ Facility Name: _____ Tel:_____Fax: _____

Signature: _____ Date:_____NPI#: _____

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