

PHYSICIAN ORDER FOR OSTOMY SUPPLIES

 NEW PATIENT

 RENEWAL/CHANGE ORDER

Patient Name		HIC #
Address		Phone
Date of Order	Length of Need 99 (months)(99=Lifetime)	D.O.B.

Medical, clinical and personal information stated on this document was provided to this supplier by one or more of the following: hospital, physician office, nursing agency, patient or caregiver. If you do not agree with the stated information please draw a single straight line through the item, state the correct information then date and initial the changes. If you have questions please contact our office.

Is the patient currently receiving services for home health? YES NO

Ostomy supplies are not separately payable when a patient is in a covered home health episode. Ostomy supplies must be provided by the home health agency and payment is included in the home health Medicare payment rate. It is not appropriate to bill these to the DMERC.

IF THIS IS THE CONFIRMATION OF A VERBAL ORDER, CHECK HERE.

Diagnosis: Must be ICD-9 Code. Narrative format is not acceptable per Medicare guidelines. Select the appropriate diagnosis.

COLOSTOMY
 569.62

 V44.3

 V55.3

ILEOSTOMY
 V44.2

 V55.2

URINARY OSTOMY
 V44.6

 V55.6

Supply Item	Medicare utilization guidelines	HCPCS Code and Description	Quantity per month	Quantity per 3 months
Paste select one	2 oz per month	<input type="checkbox"/> A4405 skin barrier, non-pectin based		
	2 oz per month	<input type="checkbox"/> A4406 skin barrier, pectin based		
Liquid barrier select one	2 oz per month	<input type="checkbox"/> A4369 liquid/spray		
	150 per 6 mo	<input type="checkbox"/> A5120 wipes/swabs, each (AU mod)		
Tape select one	40 units per mo	<input type="checkbox"/> A4450 non-waterproof (AU mod)		
	unit = 18 sq inches	<input type="checkbox"/> A4452 waterproof (AU mod)		
Irrigation supplies select all that apply	4 each per month	<input type="checkbox"/> A4397 sleeve		
	2 each per 6 months	<input type="checkbox"/> A4398 bag		
	2 each per 6 months	<input type="checkbox"/> A4399 cone/catheter including brush		

Does the patient require a greater quantity of supplies than established by Medicare utilization guidelines?

 Yes

 No

If "Yes" please provide adequate, clear documentation of the medical necessity of the amount requested. (The DME regional carrier may request copies of the patient's medical records that corroborate the order and any additional documentation that pertains to the medical necessity of items and quantities billed.)

Supplier: Core Care Technologies, Inc.	Phone: (856) 218-2476	Fax: (856) 218-0082
Address: 309 Fries Mill Road, Suite 14, Sewell, NJ 08080		NSC# 1303360001

Physician:	Phone:	Fax:
Address:		UPIN#

By signing this document I, the above named physician, agree that the above information is true and correct to the best of my knowledge and the medical supplies/equipment are medically necessary and appropriate for this patient.

Physician Signature: _____ Date: _____