Express Rx Pharmacy and Medical Supplies

1711 W. Temple St #100
Los Angeles, CA 90026
Phone: 855-349-6017 Fax: 213-674-3197

Medical Necessity & Prescription Form for Incontinence Supplies

Patient Name: ____ DOB: _______________ Gender: M F

Address: _____________________________________Telephone: _______________ID#____________________

Diagnosis: ____ **ICD-9 Code:** __________

PLEASE SPECIFY THE DISEASE OR ILLNESS CAUSING INCONTIENCE

Incontinence of (check all that apply):

[ ] **Bladder** [ ] **Overflow** 788.38 [ ] **Stress** 788.32 / 625.6 [ ] **Urge** 788.31 [ ] **Mixed** 788.33 [ ] **Functional** 788.91

[ ] **Bowel** [ ] **Nervous System Pathology** 787.60 [ ] **Functional**

Adult Briefs (Diaper type) Daily Usage: _____ changes daily

Size: [ ] Small PV-011 20"-31"-**T4521** [ ] Medium NU-012/1 32"-44"-**T4522** [ ] Large NU-013/1 45"-58" -**T4523** [ ] X-Large NU-014/1 59"-64"-**T4524**

Adult Protective Underwear Disposable (Pull-on type) Daily usage: ______ changes daily

Size: [ ] Medium PF-512 34"-46"-**T4526** [ ] Large PF-513 44"-58"-**T4527** [ ] X-Large PF-514 58"-68"-**T4528**

Insert Liners / Pads (Kotex type)

Daily Usage: _____ changes. HCPCS CODE FOR ALL: **T4535**

Size: [ ] BC-012 [ ] BC-013-LONG [ ] PV-916/1 [ ] PV-923/1

Bed Pads (Under pads) Daily Usage _____ changes. HCPCS: **T4541**

Size: [ ] 30X30 (10 PER BAG) UP-100

Cuties Baby Diapers Daily Usage: _____ changes daily HCPCS CODE FOR ALL SIZES: **T4530**

[ ] Size 4 (22-37lbs) [ ] Size 5 (27+lbs) [ ] Size 6 (35+lbs)

Sleep Over Youth Pants (Pull On Type) Daily Usage: _____changes daily.

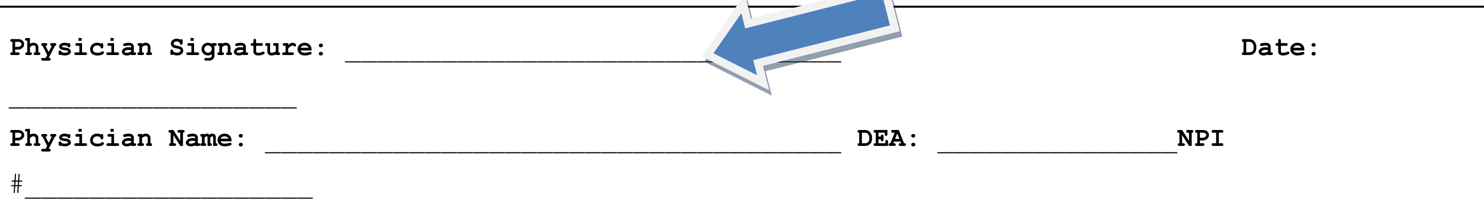
[ ] Small / Medium (45-65lbs) HCPCS: **T4534** [ ] Large / X-Large (65-125lbs) HCPCS: **T4534**

[ ] Protective Underwear Re-Usable Usage: __ per month Size____ (Maximum 2/month) HCPCS: **T4536**

[ ] Mattress protector **T4537** (Note-Maximum 1 every 6 months)

This order is for a 30 DAY SUPPLY Please dispense Quantity Sufficient Refills _____ or 1 year supply

Physician Declaration: I have reviewed the above named patient's medical records and the items ordered. I certify that these items are medically necessary for this patient's condition. I authorize these items that are checked to be filled and dispensed as ordered. I certify that the checked diagnosis is an accurate statement and is reflected in the patient's medical records / charts.



Physician Signature: ________________________________ **Date:** ___________________

Physician Name: _____________________________________ **DEA:** _______________**NPI** #___________________