



185 Grove Street
 Waterbury, CT 06710
 T: 203-575-0199
 F: 203-575-0515



500 Farmington Ave
 Hartford, CT 06105
 T: 860-522-9289
 F: 860-231-7007

Urology Order Form

Patient Name: _____ Date of Birth _____

Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's DME is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

1. Period of Medical Necessity:
 _____ New Prescription _____ Refill Prescription Order Start Date: _____ Est. length of need: _____ Months

2. Pertinent Diagnosis (ICD-10-CM Code): _____

3. Does the patient currently have Chronic or Permanent Urinary Incontinence or Retention not to be corrected in the next 90 days? Yes No

4. Equipment Prescribed: The following represents the least expensive equipment that will meet the patient's medical needs:

Intermittent Catheters	Brand/Item	French Size	Frequency per Day (Required)	
<input type="checkbox"/> Intermittent Urinary Catheter (A4351)		<input type="checkbox"/> 8 FR	<input type="checkbox"/> 2 per day/60 month/180 per 3 months	
<input type="checkbox"/> Intermittent Urinary Catheter: Coude Tip (A4352)		<input type="checkbox"/> 10 FR	<input type="checkbox"/> 3 per day/90 month/270 per 3 months	
<input type="checkbox"/> Intermittent Urinary Catheter with Insertion Supplies (A4353) <input type="checkbox"/> Straight <input type="checkbox"/> Coude Tip		<input type="checkbox"/> 12 FR	<input type="checkbox"/> 4 per day/120 month/360 per 3 months	
		<input type="checkbox"/> 14 FR	<input type="checkbox"/> 5 per day/150 month/450 per 3 months	
		<input type="checkbox"/> 16 FR	<input type="checkbox"/> 6 per day/180 month/540 per 3 months	
		Other _____	<input type="checkbox"/> Other _____	
Urological Items	Brand/Item	French Size	Quantity/Month	Frequency of Use
<input type="checkbox"/> Male External Catheters				
<input type="checkbox"/> Leg Bag				
<input type="checkbox"/> Foley Catheter <input type="checkbox"/> Two-way <input type="checkbox"/> Three-way <input type="checkbox"/> Latex <input type="checkbox"/> Silicone				
<input type="checkbox"/> Foley Insertion Trays <input type="checkbox"/> w/bag <input type="checkbox"/> w/o bag				
<input type="checkbox"/> Lubricant <input type="checkbox"/> packets <input type="checkbox"/> tube				
<input type="checkbox"/> Other:				

Please complete and sign below to indicate your acceptance of the above information and return the return via fax to 203-575-0515. We CAN now accept faxes or copies. Insurance regulations require that we must have a signed and dated copy on file. If you have any questions, please contact us at (203) 575-0199

I, the undersigned, certify that the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and are not being prescribed as "convenience" equipment.

Prescriber Name: _____ Prescriber NPI #: _____

Street Address: _____ City, ST, Zip _____

Date Signed: ____/____/____ Signature: _____

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES

Supervising Physician Name (if applicable) _____

Signing Prescribers NPI # (If Different from above) _____