INNOVA MEDICAL PRODUCTS

Northeast Medical Products, Inc

DME Order Checklist for Referring Providers

Please fax the following information to help us process your Durable Medical Equipment (DME) order quickly and accurately. Incomplete submissions are the most common cause of processing delays.

- ☐ **Patient demographics**
- ☐ **Completed Rx form**, signed and dated with either a wet signature or "Electronically signed by..."
- ☐ **Current insurance information**, with copy of front and back of insurance card
- ☐ **Medical records dated within the last 6 months**, indicating need for the equipment

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Before You Fax

- ☐ Confirm all pages are legible and complete
- ☐ Confirm the order is signed and dated by the prescriber
- ☐ Confirm all quantities are correct
- ☐ Confirm diagnosis codes, number of refills, and length of need are on the Rx and all coverage questions have been completed
- ☐ Include a cover sheet noting the number of pages and a callback number in case we have questions

Fax to: 860-388-0368

Questions? Call us at: 860-388-1437

This checklist is a general guide. Specific documentation requirements can vary by insurance payer and equipment type — our team will follow up if anything additional is needed.

Northeast Medical Products, Inc

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860-388-1437 FAX: 860-388-0368
www.northeastmedicalproducts.com
An Innova Medical Group Company

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CATHETER PRESCRIPTION FORM

Patient Information:

Patient Name _____ DOB _____

Address _____

Email _____

Phone _____ Alt Phone _____

Alternate Contact Name _____ Relationship _____ Phone _____

Diagnosis:

- ☐ Retention of Urine (R33.9)
- ☐ Incomplete Bladder Emptying (R39.14)
- ☐ Other Specified Retention of Urine (R33.8)
- ☐ Urinary Incontinence (R32)
- ☐ Urge Incontinence (N39.41)
- ☐ Other Diagnosis _____

Order Date _____

Length of Need _____ ☐ 12 months (One Year) _____ Number of refills

Does Patient Have Permanent Urinary Incontinence or Retention? ☐ Yes ☐ No

(Note: Permanency is defined as a condition that is expected to last greater than 90 days)

Please Check Desired Product and Indicate Size & Quantity in Box Provided

Supplies		Size	Quantity to Dispense
Straight Intermittent (A4351) *	☐	Fr _____	____ Per month
Coude Intermittent (A4352) **	☐	Fr _____	____ Per month
Foley Catheter Indwelling (A4338)	☐	Fr___ Balloon(cc) 5___30___	____ Per month
External Cath (A4349)	☐	23-28-32-36 mm	____ Per month
Lubricant Packet (A4332) / Lubricant Tube (A4402)	☐		____ Per month
Overnight Drain Bag (A4357)	☐		____ Per month
Leg Bag (A4358)	☐		____ Per month

** When a Straight Intermittent catheter is used, there must be documentation in the beneficiary's medical record of the medical necessity for that catheter and that there has been a history of UTIs 2x within the last 12 months*

***When a Coude tip catheter is used there must be documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter.*

PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT
(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)

Physician Information:

Physician Name _____ NPI _____

Office Address _____ City, State, Zip _____

Phone _____ Fax _____

_____ _____

Physician Signature Date