Northeast Medical Products, Inc

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An Innova Medical Group Company

INNOVA MEDICAL PRODUCTS

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