Physician Order, Rx and Certificate of Medical Necessity for Ostomy Supplies

FAX ORDERS TO 800.340.2955

Start Date: _____

Patient Name: _____ DOB: _____ Sex: M / F

Address: _____ Phone: _____

Physician: _____ Phone: _____

Physician Address: _____

For Office Use Only
Rec'd: _____
Ins Ver.: _____
_____
Ordered: _____
Delivered: _____

QTY	DESCRIPTION	HCPCS
	Pouch ___ One Piece ___ Two Piece	
	Flange w/Skin Barrier to use with Two Piece Pouch (box)	
	Skin Barrier 2oz (each) ___ Paste ___ Powder	
	Skin Prep Wipes (box)	
	Adhesive Remover Wipes (box)	
	Skin Barrier Wafer Solid (box) ___ 4"x 4" ___ 6"x 6" ___ 8"x 8"	
	Tape (roll) ___ Paper ___ Cloth ___ Waterproof ___1" ___ 2" ___ 3"	
	Night Urinary Drainage Collector (each)	
	Bedside Urinary Drainage Bag 2000cc	
	Others:	
	Others:	

Physician Use Only: Prescription

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRECCRIBER WRITES 'd a w' IN THE BOX

Dispense as Written ☐

Dispense:
___ 1 Month Supply
___ 3 Month Supply

DIAGNOSIS

___ K94.00 Colostomy Complication, Unspecified

___ K94.10 Enterostomy Complication, Unspecified

___ K94.03 Colostomy Malfunction

___ K94.13 Enterostomy Malfunction

___ Z93.2 Ileostomy Status

___ Z93.3 Colostomy Status

___ Z93.6 Other artificial openings of urinary tract status

___ Other (Prognosis and size of stoma)

___ Z43.2 Encounter for attention to Ileostomy

___ K43.3 Encounter for Attention to Colostomy

___ K43.6 Encounter for Attention to other artificial openings of Urinary Tract

Allergies to products applied to skin? Y / N

_____

Allergies to Latex?: Y / N

_____

_____

(Physician Signature M.D. or D.O.) ***NPI #*** ***Date***

**If a CRNP or PA signs Rx, to meet Medical Guidelines an M.D. or D.O. wet ink must accompany signature.*

Reliant Medical Supply

3111 S Valley View Blvd Ste. A220 Las Vegas NV 89102 | Office 702.433.0464

Instructions to Ostomy Form

Instructions - Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to Reliant Medical. If you have any changes, please cross out; write in correction, sign, and date.

Dear Doctors/Prescribers,

A. Please complete the patient information and doctor information sections.
Please indicate the products you want supplied to the patient, with directions for use and quantity required;

B. Please sign and date on the spaces provided.

C. Some Medicare Coverage Rules that should be noted:
   a) Medicare reimbursement limits Ostomy Supplies to a three (3) months supply at one time.
   b) If treatment regimen exceeds the quantity limitations noted below, then Medicare requires a Letter of Medical Necessity signed by the physician on his or her letterhead.
   c) If you fax this document, Medicare/insurance requirements are that you maintain the signed original in the patient's medical record for postpayment review audit purposes.

Medicare Guidelines for Ostomy Supplies

Note: Monthly allowable amounts do not represent a benefit limit. The actual quantity needed by a particular customer may be more or less than the amount listed, depending on the individual customer's medical condition. Customers ordering over the allowable amount must have appropriate medical justification (i.e. a letter of medical necessity)

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned certify that the above prescribed is medically necessary for the patients' overall wellbeing. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

OSTOMY SUPPLIES ORDER GUIDE FOR QUANTITY LIMITATIONS

Products	Quantity Limitations	Products	Quantity Limitations
Adhesives and Adhesive movers	CASH PURCHASE	Other	
Adhesive (Cement), Liquid Or Equal, Any Type, Per Oz (A4364)	4 oz per month	Appliance Cleaner, Incontinence And Ostomy Appliances, Per 16 Oz. (A5131)	16 oz per month
Adhesive Remover Or Solvent (For Tape, Cement Or Other Adhesive), Per Ounce (A4455)	8 oz per 3 months 16 oz per 6 months	Bedside Drainage Bag, Day Or Night, With Or Without Anti-Reflux Device, With or Without Tube, Each (A4357)	2 ea per month
Adhesive Or Non-Adhesive; Disk Or Foam Pad (A5126)	20 per month	Bedside Drainage Bottle With Or Without Tubing, Rigid Or Expandable, Each (A5102)	1 ea every 3 months 2 ea every 6 months
Pouches	CASH PURCAHSE	Belt, Ostomy (A4367)	1 ea per month
Ostomy Pouch, Closed (A5051, A5052, A5053, A5054)	Up to 60 per month	Continent Device; Catheter For Continent Stoma (A5082)	1 per month
Ostomy Pouch, Drainable – 2 piece (A5063)	Up to 20 per month	Continent Device; Plug For Continent Stoma (A5081)	31 per month
Ostomy Pouch, Drainable – 1 piece (A5062, K0567, K0568)	Up to 20 per month	Gauze, Non-Impregnated, Non-Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing (A6216)	60 per month
Ostomy Pouch, Drainable, For Use On Faceplate, Plastic, Each (A4377)	10 per month	Irrigation Supply; Sleeve, Each (A4397)	4 per month
Ostomy Pouch, Urinary, For Use On Faceplate, Plastic, Each (A4381)	10 per month	Lubricant, Per Ounce (A4402)	4 oz per month
Ostomy Pouch, Urinary – 2 piece (A5073)	20 per month	Ostomy Accessory; Convex Insert (A5093)	10 per month
Ostomy Pouch, Urinary – 1 piece (A5071, A5072)	20 per month	Ostomy Faceplate, Each (A4361)	3 per 6 months
Wafers/Flanges	CASH PURCHASE	Ostomy Irrigation Supply; Bag, Each (A4398)	2 per 6 months
Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion) (K0570, K0571, A4414, A4415)	20 per month	Ostomy Ring, Each (A4404)	10 per month
Skin Barrier; Solid, 4”x4”, 6”x6”, or 8”x8” (A4362, A5121, A5122)	20 per month	Stoma Cap (A5055)	31 per month
Skin Barriers		Tape, per 18 Square Inches (A4450, A4452)	Varies by region. Approx. 2 rolls of 1” tape per month
Ostomy Skin Barrier, Liquid (Spray, Brush, Etc), Per Oz (A4369)	2 oz per month		
Ostomy Skin Barrier, Paste, Per Ounce (K0561, K0562, A4405, A4406)	4 oz per month		
Ostomy Skin Barrier, Powder, Per Oz (A4371)	5 oz per 3 months 10 oz per 6 months		
Skin Barrier; Wipes, Box per 50 (A5119)	150 per 6 months		

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