OSTOMY ORDER FORM

Phone: (888) 244-6421
Fax: (800) 975-6321
WEB: WWW.PRISM-MEDICAL.COM

In order to process your patient's order we need the following documentation faxed along with this completed form:

1. **PATIENT DEMOGRAPHICS** - (Insurance & Physical Address)

REFERRING FACILITY	
NAME	
CITY/STATE	
PHONE	
FAX	

CASE MANAGER

NOTES

PATIENT INFORMATION	
RX DATE	
PATIENT'S NAME	

Is this patient currently being seen by Home Health Services?	Yes	No
Is the patient allergic to latex?	Yes	No
Has the patient been instructed on the use of the requested supplies?	Yes	No

✓	DIAGNOSIS
	COLOSTOMY
	UROSTOMY
	ILEOSTOMY
	OTHER:

STOMA SIZE

✓	ESTIMATED TIME OF NEED
	99 = LIFETIME
	OTHER: _____

ITEM	BRAND/PART #	FREQUENCY OF USE	QUANTITY TO DISPENSE
OSTOMY POUCH—ONE PIECE			
OSTOMY POUCH– TWO PIECE			
FLANGE WITH SKIN BARRIER			
SKIN BARRIER PASTE			
SKIN BARRIER POWDER			
SKIN BARRIER WAFER (SOLID) *SIZE:*_____			
URINARY DRAINAGE BAG *TYPE:*_____			
ADHESIVE REMOVER WIPES			
SKIN PREP WIPES			
TAPE *TYPE:*_____			
OTHER:			

PROVIDERS APPROVAL	
(PRINT NAME)	
NPI #	
SIGNATURE	* DATE:_____

* I attest by my signature that 1) the requested supplies are medically necessary and it is my intention for this prescription to remain valid until the underlying disease/diagnosis described above is resolved, or otherwise directed by the signer, 2) the patient has been instructed on the specific use of the requested supplies and is competent to use them, and 3) the supplier should provide the requested supplies in 3 month intervals pursuant to the associated Local Coverage Determination for Ostomy Supplies, unless otherwise indicated.

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S SIGNATURE	X

SUBMIT