PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Beneficiary Information

Name: _____ Date of birth: _____ Age: _____

Medicaid ID: _____Height: _____ Weight _____

Beneficiary's Address

_____

Prescribing Provider:

Prescriber's Name: _____ Phone #: _____

Address: _____Fax # _____

➤ **Medical Diagnoses causing the urine and/or fecal incontinence:**

Primary: **Secondary:**

_____ _____

➤ **Specify Urine/Fecal incontinence diagnoses:**

Primary: **Secondary:**

_____ _____

➤ **Mobility**

☐ Ambulatory ☐ Minimal assistance ambulating

☐ Transfer Assistance ☐ Confined to bed or chair

➤ **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

➤ **Mental Status/Level of Orientation**

☐ Has the ability to communicate needs

☐ Sometimes communicates needs

☐ Unable to communicate needs

Frequency of anticipated change

During Day time (6 AM-10PM) _____.

During Night time (10PM – 6 AM) _____.

➤ **Additional supporting Diagnoses**

_____

_____

Indicate current supportive services

☐ Home Health

☐ Skilled Nursing Services

☐ Personal Care Services

☐ Other _____

➤ **List any medications and/or nutritional therapy that would increase urine or fecal output:**

_____

➤ **Specify incontinence supply, size, quantity/24 hours and duration of need:**

					Qty per day	Size (S, M, L, XL)
☐	**Diapers (Check one):**	☐ **child size**	☐ **youth-sized**	☐ **adult-sized**	_____	_____
☐	**Pull-ups (Check one):**	☐ **child size**	☐ **youth-sized**	☐ **adult-sized**	_____	_____
☐	**Liner/shield (Check one):**	☐ **child size**	☐ **youth-sized**	☐ **adult-sized**	_____	_____

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

_____

Date:

_____

➤ **Comments**

_____

_____

_____

_____

_____

☐ **Additional documentation attached**