Byram® HEALTHCARE

Please fax to: 1-866-992-6331

Email: hbneworders@byramhealthcare.com

Referral Number:

Referral Name, Address and Phone:

Incontinence Order Form

▸ Required Information ❑ Face Sheet Attached

PATIENT INFORMATION:

Patient Name (Last, First):_____ Date of Birth (MM/DD/YY):_____

▸Street:_____

▸City:_____ State:_____ Zip Code:_____

▸Phone Number:_____ Mobile Number:_____

Language: ❑ English ❑ Spanish ❑ Other:_____ Email:_____

▸Primary Insurance: _____ ID#_____ Phone:_____

▸Secondary Insurance :_____ ID#_____ Phone:_____

Start Date:_____ ▸Length of need: 99=Lifetime unless otherwise indicated. ❑ Other:_____ Months

▸Primary Diagnosis (Cause of Incontinence): _____ Latex Allergy? ❑ Yes ❑ No

Type of Incontinence: ❑ Permanent Urinary Incontinence R32 ❑ Mixed Incontinence N39.46

❑ Incontinence with Feces R15.9

RECOMMENDED SUPPLIES:

Items	Size	HCPCS Code	Monthly Allowable
Adult Briefs (Diapers)	☐ Small 20" to 31"	T4521	
	☐ Medium 32" to 44"	T4522	
	☐ Large 45" to 58"	T4523	
	☐ X-Lrg 59" to 64"	T4524	
	☐ Disposable Brief/Diaper, Bariatric	T4543	
Adult Protective Underwear (Pull-Ups)	☐ Small 20" to 34"	T4525	
	☐ Medium 32" to 44"	T4526	
	☐ Large 44" to 58"	T4527	
	☐ X-Lrg 58" to 68"	T4528	
Pediatric Diapers & Pull-Ups	☐ Diapers (check size chart) Small & Medium	T4529	
	☐ Diapers (check size chart) Large & X-Lrg	T4530	
	☐ Pull-Ups (check size chart) Small & Medium	T4531	
	☐ Pull-Ups (check size chart) Large & X-Lrg	T4532	
Youth Briefs (Diapers)	☐ Diapers (check size chart) Youth	T4533	
Youth Protective Underwear (Pull-Ups)	☐ Pull-Ups (check size chart) Youth	T4534	
Underpads	☐ Disposable 23" x 36"	T4541	
Bladder Control Pads	☐ Moderate 11"	A4520	
	☐ Long Max 13"	A4520	
Gloves*	☐ Gloves	A4927	
*only approved for members living at home			

NAME, NPI# NAME, NPI# NAME, NPI#

❑ ❑ ❑

Licensed Healthcare Provider's Acknowledgement: My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Byram Healthcare regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

▸Licensed Healthcare Provider's Signature: _____ ▸Date:_____

Signature stamps are NOT acceptable Date stamps are NOT acceptable

For more information, please call: 1-800-364-6057