Byram HEALTHCARE®

Part of the Owens & Minor Family

Please fax to: 1-866-992-6331 HB

Email: hbneworders@byramhealthcare.com

Referral Number: **1234567890**

Referral Name, Address and Phone:

Urology 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:_____

PLAN OF CARE:

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

Does patient have UTI history (at least 2 within last 12 months)? ❑ Yes* ❑ No

*If yes, and the patient's insurance provider follows Medicare guidelines, fax a copy of lab work and supporting documentation along with this form.

Latex Allergy? ❑ Yes ❑ No

▸ICD10 Diagnosis: ❑ Enuresis not due to a substance or known physiological condition F98.0

❑ Neuromuscular dysfunction of bladder, unspecified N31.9 ❑ Retention of urine, unspecified R33.9

▸❑ Primary/Causal Diagnosis:_____

RECOMMENDED SUPPLIES:

Urological Items	Brand Preference	French Size/Length	Frequency of Use	Qty/Mo
Intermittent Catheters ❑ Straight ❑ Coudè ❑ Hydrophilic ❑ Silicone ❑ Red Rubber ❑ PVC				
Closed System Intermittent Catheter ❑ Straight ❑ Coudè				
Closed System Intermittent Catheter (includes insert. suppl.) ❑ Straight ❑ Coudè				
Male External Catheters				
Leg Bag				
Foley Catheter ❑ Two-Way ❑ Three-Way ❑ Latex ❑ Silicone				
Foley Insertion Trays ❑ with bag ❑ without bag				
Lubricant ❑ packets ❑ tube *(Medicare covers one packet per catheter.)*				
Other				

Incontinence Items	Size/Type	Frequency of Use	Qty/Mo
Diapers			
Pullups			
Liners			
Other			

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: _____ Signature stamps are NOT acceptable

Date stamps are NOT acceptable

▸Date:_____

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