CATHETER PRESCRIPTION

HOME CARE TOGETHER, INC
FAX TO: 888.299.5568

PATIENT: ______________________ ☐ M ☐ F DOB: ______________

* *FDA & Medicare have determined that intermittent catheters* ***(sterile or clean technique)*** *are to be used* ***only once*** *and then should be discarded . (ie: Speedicath)* **PLEASE ORDER ACCORDINGLY!**

QUANTITY PER DAY	Type of Catheter Needed	MEDICARE ALLOWABLE
______	INTERMITTENT **STERILE** (Touch-less closed system) **	Up to 200/MO*
______	INTERMITTENT **CLEAN** CATHETER **	UP to 200/MO*
______	LUBRICANT	1 pk/MO
______	EXTERNAL CATHETER **	Up to 35/MO
______	FOLEY PROCESS **	1/MO (Doctor Insertion)
______	FOLEY CATHETER INSERTION TRAY	1/MO
______	(Circle 1) LEG BAG (vinyl) or BELLY BAG ___________ OZ	2/MO
______	BEDSIDE DRAIN COLLECTION (Circle) 2000cc 4000cc	2/MO
______	______________________________	

** **INDICATE SIZE HERE:**

Length of Need: __________ *(99 = LIFETIME)*

QUANTITY PER DAY	ADDITIONAL NEEDED SUPPLIES	MEDICARE ALLOWABLE
______	WIPES	2/BX/MO
______	DISPOSABLE BED PADS (CHUX)	5/PKS/MO
______	GLOVES ___ LATEX ___ VINAL	2/BX/MO

OTHER INSTRUCTIONS:

DIAGNOSIS CODES (ICD-9) & CONDITIONS INCLUDE:

CODE	CONDITION	CODE:	CONDITION	CODE:	CONDITION:

DOCUMENTATION: *By signing this prescription I certify that the medical records for this patient indicate urination impairment, retention, or incontinence for at least three (3) months. For sterile technique I certify this patient has the appropriate conditions and it is well documented in the patient's chart/records. I will provide evidence of medical necessity in case of a Medicare audit.*

______________________________ ______________
Physician's Signature *Date*

______________________________ ______________
Please Print your name *NPI #*

Date Prescription Received

Office Use Only