




# OSTOMOY SUPPLIES PRESCRIPTION

HOME CARE TOGETHER, INC

FAX TO: 888.299.5568

PATIENT: \_\_\_\_\_ DOB \_\_\_\_\_

We offer these fine brands; please check preference:

- 
 
 
 Other:
- Hollister
  No Preference

Please indicate model information (please be specific):

QUANTITY PER DAY	Type of Catheter Needed	MEDICARE ALLOWABLE
_____	POUCHES, 1 OR 2 PIECE DRAINABLE	Up to 20/ MO
_____	CLOSED END POUCHES	Up to 60/MO
_____	SKIN BARRIER PASTE	2oz/ MO
_____	POWDER	2oz/MO
_____	NIGHT DRAINAGE BAG	2/MO
_____	NIGHT DRAINAGE BOTTLE	1/ EVERY 3 MOS.
_____	APPLIANCE CLEANER	16 OZ/MO
_____	SKIN BARRIER PREP WIPES	Up to 150/ 3 MOS.
_____	IRRIGATION BAG	1 every 3 MOS
_____	IRRIGATION SLEEVE	1 ever 4 MOS
_____	STOMA CAPS	Up to 31/MO
_____	<i>Other Supplies:</i> _____	

INDICATE SIZE HERE: \_\_\_\_\_ **Length of Need:** \_\_\_\_\_ (99 = LIFETIME)

**DIAGNOSIS CODES (ICD-9) Circle One:**

**569.60** ~ Colostomy & Enterostomy Complication Unspecified     **569.62** ~ Mechanical Complication of Colostomy & Enterostmy  
**V44.2** ~ Ileostomy Status     **V44.3** ~ Colostomy Status     **V44.6** ~ Status of Other Artificial Opening of Urinary Tract

**DOCUMENTATION:** *If this patient requires more than Medicare guideline supplies, we must have documentation that is supported by patient's medical charts/records and provided to us for our records.*

<i>Physician's Signature</i>	<i>Date</i>	Date Prescription Received
<i>Please Print your name</i>	<i>NPI #</i>	
		Office Use Only