PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY FOR INCONTINENCE SUPPLIES

Patient Name/Address: DOB:	**Supplier's Name/Address/Phone/NSC #** 4999540001
Name:_____ Address:_____ Tel:	Diabest, Inc. 133 Smith Street Perth Amboy, NJ 08861 Tel: 732-293-0002,Fax: 732-293-0003 Email:Diabest2004@yahoo.com
HIC# Sec #	**Refills:** ☐ **12 Months** or_____**Months**
Diagnosis and ICD-9 Codes a) ☐ Urinary Incontinence (788.30) b) ☐ Feces Incontinence (787.6) c) ☐ Mixed Incontinence (788.33) d) ☐ Stress Incontinence Male (788.32) e) ☐ Stress Incontinence Female (625.6) f) _____(Other)	Prognosis: Last Examination Date: HT: _____ WT: _____

QTY	EQUIPMENT	CPT/HCPCS Codes	ANSWER QUESTION(S)
	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER	T452__ (1, 2, 3, 4)	1,2,3
	DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON	T452__ (5, 6, 7, 8)	1,2,3
	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD	T454__ (1, 2)	1,2,3
	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT	T4535	1,2,3
	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD OR UNDERWEAR, REUSABLE	T45__(36,37,38,39 40,41,42)	1,2,3
	NON-STERILE GLOVES	A4927	1
	CATHETERS		1

PLEASE ANSWER ALL QUESTIONS APPLICABLE TO THE EQUIPMENT INDICATED ABOVE:

1. Does the patient have permanent incontinence? **Diagnosis code should be documented on the top portion of this form.**	☐ Yes ☐ No
2. How many diapers/briefs per day does this patient require?	Quantity:
3. How many under pads per day does this patient require?	Quantity:
Other notes by the prescribing doctor:	

I certify the medical necessity of these items for this patient.

Physician's Name:		
Address:	City:	
UPIN #:	License #	Phone #:
Signature Of Prescribed Physician's:		**Date** _____/_____/_____