Urology Order Form

Form must be signed then faxed to **(888) 868-2872**

Patient Information — **Please Attach History and Chart Notes**

Patient Name	Gender ☐ Female ☐ Male	Date of Birth (MM/DD/YY)

Street Address	City	State	Zip

Phone Number	Email

Primary Insurance	Member ID #

Intermittent Catheters	Brand / Item	French Size	Frequency per Day (Required)
☐ **Intermittent Urinary Catheter (A4351)**		☐ 8 FR ☐ 10 FR ☐ 12 FR ☐ 14 FR ☐ 16 FR Other ____	☐ 2 per day / 60 month / 180 per 3 months ☐ 3 per day / 90 month / 270 per 3 months ☐ 4 per day / 120 month / 360 per 3 months ☐ 5 per day / 150 month / 450 per 3 months ☐ 6 per day / 180 month / 540 per 3 months
☐ **Intermittent Urinary Catheter: Coude Tip (A4352)**			
☐ **Intermittent Urinary Catheter with Insertion Supplies (A4353)** Other _____			

Urological Items	Brand / Item	French Size	Quantity/Month	Frequency of Use
Male External Catheters				
Leg Bag				
Foley Catheter ☐ Two-Way ☐ Three-Way ☐ Latex ☐ Slicone				
Foley Insertion Trays ☐ w/bag ☐ w/o bag				
Lubricant ☐ Packets ☐ tube				

Physiscian Name	NPI	Tax ID

Office Name	Street Address	City	State	Zip

Phone Number	Fax

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 they will be contacted by Assurace-Med regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

_____ **Provider Signature**

_____/_____/_____ **Date**