

Urology Order Form

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



Patient Information

Please Attach History and Chart Notes

Patient Name		Gender <input type="checkbox"/> Female <input type="checkbox"/> 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)
<input type="checkbox"/> Intermittent Urinary Catheter (A4351)		<input type="checkbox"/> 8 FR	<input type="checkbox"/> 2 per day / 60 month / 180 per 3 months
<input type="checkbox"/> Intermittent Urinary Catheter: Coude Tip (A4352)		<input type="checkbox"/> 10 FR	<input type="checkbox"/> 3 per day / 90 month / 270 per 3 months
<input type="checkbox"/> Intermittent Urinary Catheter with Insertion Supplies (A4353) Other _____		<input type="checkbox"/> 12 FR	<input type="checkbox"/> 4 per day / 120 month / 360 per 3 months
		<input type="checkbox"/> 14 FR	<input type="checkbox"/> 5 per day / 150 month / 450 per 3 months
		<input type="checkbox"/> 16 FR	<input type="checkbox"/> 6 per day / 180 month / 540 per 3 months
		Other _____	

Urological Items	Brand / Item	French Size	Quantity/Month	Frequency of Use
Male External Catheters				
Leg Bag				
Foley Catheter <input type="checkbox"/> Two-Way <input type="checkbox"/> Three-Way <input type="checkbox"/> Latex <input type="checkbox"/> Silicone				
Foley Insertion Trays <input type="checkbox"/> w/bag <input type="checkbox"/> w/o bag				
Lubricant <input type="checkbox"/> Packets <input type="checkbox"/> tube				

Physician 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

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