DELTADRUGS

Incontinence Supplies

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 800.700.6401 • **FAX:** 866.700.6401 • info@deltadrugs.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Weight (lbs): _____ Height (in.): _____

Insurance: _____ ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

ICD-10 DIAGNOSIS

Primary Diagnosis

❑ _____ _____

❑ _____ _____

Secondary Diagnosis

❑ N31.9 Neuromuscular Dysfunction of Bladder

❑ R32 Unspecified Urinary Incontinence

❑ N39.46 Mixed Incontinence

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

ITEM	QTY	FREQUENCY USE
❑ DISPOSABLE BRIEFS	192-216	192 briefs/27 days
❑ PULL-UPS	120	120 pull-ups/27 days
❑ DISPOSABLE INSERTS / LINERS	180	180 disposable Inserts/27 days
❑ REUSABLE UNDERPANTS	2	2 reusable underpants/27 days
❑ UNDER PADS	120	120 underpads/27 days
❑ SKIN CARE WASH (21 YRS & YOUNGER)	4 bottles	948mL/27 days
❑ SKIN CARE CREAM (21 YRS & YOUNGER)	2 jars	540g/27 days
❑ MATTRESS PROTECTOR	2	1 mattress protector every 6 months
❑ GLOVES	100-200	Up to 200/27 days
❑ UNDERGARMENT/LINERS (2 PRODUCTS)	300	Up to 300/27 days

Incontinence supplies are covered by Medi-Cal for use in chronic pathologic conditions casually related to the patient's incontinence when prescribed by a licensed practitioner within the scope of his/her practice. The patient identified as being under your care (or his/her representative) has requested the incontinence supplies listed above. This completed and signed order, which is valid for up to twelve (12) months, must be in the possession of the medical supply provider for the items to be supplied to your patient.

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

BY SIGNING, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to any insurer or authorized agents, if required.