

INCONTINENCE PRESCRIPTION

Date _____

Patient Name _____ DOB _____

Address _____ Phone # _____

Insurance Provider _____ Policy Number _____

DIAGNOSIS:

- ☐ Urinary Incontinence (R32) ☐ Stress Incontinence (N39.3)
☐ Mixed Incontinence (N39.46) ☐ Incontinence w/ feces (R15.9)

SECONDARY DIAGNOSIS (if applicable): _____

LENGTH OF NEED: ☐ 99 Months ☐ _____ Months

PRODUCT

Items	HCPC	Size (Please select which item(s) are being ordered)	Qty to be provided each month (Please indicate a quantity being ordered)
Adult disposable diapers (briefs)	T4521	☐ Sm - 20" - 31"	
	T4522	☐ Med - 32" - 44"	
	T4523	☐ Lrg - 45" - 58"	
	T4524	☐ XLrg - 59" - 64"	
	T4543	☐ XXLrg+ - 65" +	
Adult Protective Underwear (Pull-on style)	T4525	☐ Sm - 20" - 34"	
	T4526	☐ Med - 34" - 44"	
	T4527	☐ Lrg - 45" - 58"	
	T4528	☐ XLrg - 59" - 68"	
	T4544	☐ XXLrg+ - 68" +	
Pediatric Diapers	T4529	☐ Sm/Med (Size 1,2, and 3)	
	T4530	☐ Lrg/XLrg (Size 4,5, and 6)	
Pediatric Pull-ups	T4531	☐ Sm/Med	
	T4532	☐ Lrg/XLrg	
Youth Diapers (Briefs)	T4533	☐ Youth	
Youth Protective Underwear (Pull-on style)	T4534	☐ Youth	
Liners	T4535	☐ Sm, Med, or Lrg (circle one)	
Underpads/Chux	T4541	☐ Lrg	
Gloves	A4927	☐ Sm, Med, or Lrg (circle one)	

ORDERING PHYSICIAN:

Provider Name _____ Phone _____ Fax _____

Provider Address _____

Provider Signature _____ Date _____ NPI _____

Fax the completed form and patient records to 781.987.8206 or email to priorityservice@reliableurology.com