INCONTINENCE SUPPLIES SCRIPT

Please send completed form along with patient's face sheet & applicable clinical notes

PHONE: (718) 854-5501 FAX: (718) 369-5858

Patient Name:	**Date of Birth:**_____/_____/_____ ☐M ☐F
Address: _____	**Height:** _____ **Weight:** _____

DIAGNOSIS	HCPCS	ITEM DESCRIPTION	QTY
URINARY INCONTINENCE		**ADULT BRIEFS/DIAPERS**	
☐ N39.41 (Urge)	☐ T4521	ADULT SIZED BRIEF/DIAPER (SMALL)	250
☐ N39.3 (Stress)	☐ T4522	ADULT SIZED BRIEF/DIAPER (MEDIUM)	250
☐ N39.46 (Mixed)	☐ T4523	ADULT SIZED BRIEF/DIAPER (LARGE)	250
☐ N39.42 (Without sensory awareness)	☐ T4524	ADULT SIZED BRIEF/DIAPER (X-LARGE)	250
☐ N39.43 (Post-void dribbling)		**BARIATRIC ADULT BRIEFS/DIAPERS**	
☐ N39.44 (Nocturnal enuresis)	☐ T4543	BARIATRIC ADULT SIZE BRIEF/DIAPER (ABOVE XL)	250
☐ N39.45 (Continuous leakage)		**OTHER SUPPLIES**	
☐ N39.490 (Overflow)	☐ T4529	PEDIATRIC SIZED BRIEF/DIAPER (SMALL/MEDIUM)	250
☐ R39.81 (Functional urinary)	☐ T4530	PEDIATRIC SIZED BRIEF/DIAPER (LARGE)	250
☐ R32 (Unspecified urinary)	☐ T4533	YOUTH SIZED DISPOSABLE BRIEF/DIAPER	250
	☐ T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD	250
FECAL INCONTINENCE	☐ T4537	BED SIZE, PROTECTIVE UNDERPAD (REUSABLE)	2
☐ R15.9 (Full)	☐ T4539	INCONTINENCE, DIAPER/BRIEF (ANY SIZE)	5
☐ R15.0 (Incomplete defecation)	☐ T4540	CHAIR SIZE, PROTECTIVE UNDERPAD (REUSABLE)	2
☐ R15.1 (Fecal smearing)	☐ A4554	DISPOSABLE UNDERPAD (ALL SIZES)	300
☐ R15.2 (Fecal urgency)	☐ A4927	GLOVES, NON-STERILE	1BOX/100PCS
	☐ A5120	WIPES OR SWABS	50
***Progress note required**	☐ T4535	DISPOSABLE LINER/PAD	250
	*** The maximum allowable quantity for the combination of diapers/pull-ons, liners, and pads is 250 per month.**		

Start Date:_____/_____/_____ **Length of Need (# of months)**_____**1-99 (99 = Lifetime)**

Indicates Additional Documentation will be required for Medicare Orders

Prescriber Name:	**Address:** _____	**Phone #:**
		Fax #:
Prescriber Signature	**Date:**	**Prescriber NPI #:**
X_____	_____/_____/ _____	