Oklahoma HealthCare Authority

Physician Order for Incontinence Supplies

(Diapers, Pull-Ons, Underpads and Wipes)

Section I:

Physician's printed name: _____	**Member name:** _____
	RID: _____
Provider ID or NPI: _____	**DOB:** _____
	Address: _____
Phone number: _____	**Phone number:** _____

Member's:
Weight _____ (lbs.) Waist Size _____ (in)

Type of incontinence:
____ Urinary _____ Bowel _____ Both

Incontinence Diagnosis Code: _____ _____ _____

Other Diagnosis related to need for Incontinence supplies (list specific diagnosis codes)

_____ _____ _____ _____ _____ _____ _____

Other devices used by member: ___ Urinary Catheter ___ Ostomy Bag ___ Other _____

Mobility:
___ Ambulatory w/o assistance
___ Ambulatory w/ assistance
___ Non Ambulatory

Cognitive Function:
___ Able to communicate needs
___ Unable to communicate needs

Type of treatment initiated:
___ None
___ Bowel/Bladder program _____
___ Medications _____
___ Surgical _____
___ Other _____
___ N/A

_____ **Needs Hypo-allergenic Products Due To Allergy**

Expected Length of Need:
_____ Months OR
_____ Lifetime

Absorbent Products Ordered:
Diapers: _____ #/month Pull-Ons _____ #/month Liners/Shields _____ #/month
Underpads: Disposable _____ #/month Underpads: Reusable: Bed size _____ #/month **OR**
Wipes: _____ #/month Chair size _____ #/month

Physician Signature:_____ **Date:** _____

Upon completion of Section I please fax to 1-844-845-1076 OR 580-924-1925

DME Supplier Prior Authorization Request Section

Section II

DME Supplier			**DME Supplier Contact Person**	**Assignment Code 12 – DME**
Name: People First Industries			**Name:**	**Date Span of Service**
DME Provider ID: 1992975700			**Phone #: 1-866-895-9956**	**From:_____to: _____**
Line Item	**HCPCS Code**	**Modifier**	**Description (Must Be On One Line Item)**	**Total Units for Date Span**
A				
B				
C				
D				
E				
F				