200 PHARMACY
& MEDICAL SUPPLIES

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INCONTINENCE – CERTIFICATE OF MEDICAL NECESSITY

MEDICAID requires a certifying physician (Primary Doctor's) signature for Incontinence Supplies. Please fill out where indicated by asterisks, and return via fax/ mail.

Patients Name: _____ D.O.B: _____

Patients Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ ☐ FEMALE ☐ MALE

Medicare #: _____ Medicaid #: _____Other: _____

Diagnosis: _____

Please Check Items – Circle Sizes:

- ☐ Diapers (per case) Size: __ Small(96) __ Med(96) __ Large (72) __ X-Large (60) **QTY:** _____Cases
- ☐ Pullups (per case) Size: __ Small(88) __ Med(80) __ Large(72) __X-Large (56) **QTY:** _____Cases
- ☐ Undergarments (per case): Size: One Size Fits All (120) **QTY:** _____Cases
- ☐ Underpads (per case): Size: 23x36 (150) **QTY:** _____Cases
- ☐ Incontinence Liners (120)
- ☐ Gloves (2 box max)

REFILLS (MONTHS): 1 2 3 4 5 6 or 1 Year **(CIRCLE ONE)**

- ☐ Bedside Commode Size: __Standard (up to 300 lbs.) __Heavy Duty (up to 450 lbs.)
- ☐ Shower Chair (with Back)
- ☐ Transfer Bench (with Back)
- ☐ Raised Toilet Seat
- ☐ Tub Bars
- ☐ Other: _____
- ✓ THIS PATIENT REQUIRES THE ABOVE SUPPLIES

Physician Name: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

YOUR PROMPT RESPONSE IS MOST APPRECIATED