PROMED DME

Toll Free: 1-844-693-6316
Fax Order To: 844-972-1531
Email Order To: Neworders@promed-dme.com

Urology Physicians Order Form: Chart notes must include the need for the supplies ordered

Rep: _____ **Referral Source:** _____

Patient Name: _____ Patient DOB: _____

Patient Phone: _____ Patient Email: _____

Insurance Policy: _____ ID #: _____

DIAGNOSIS (Check appropriate diagnosis below)

☐	R33.9– Urinary Retention	☐	R32 – Urinary Incontinence	☐	Other Primary Diagnosis: _____
☐	Duration of Need: ___ mo. If not otherwise noted, duration= 99 months	☐	UTI History (Please fax a copy of U/A and Culture with this form)	☐	Latex Allergy

CATHETER PRODUCT TYPES (HCPCS)

☐	Straight Catheter (A4351) w/ Lubricant	☐ 8FR ☐ 10FR ☐ 12FR ☐ 14FR ☐ 16FR ☐ 18FR ☐ Other: ___
☐	Catheter Kit (A4353) w/ Insertion Supplies	
☐	Coude Catheter (A4352) w/ Lubricant	
☐	Foley Catheter (A4338)	
☐	Foley Catheter (A4340) Coude	
☐	Foley Catheter (A4344) Silicone	
☐	Insertion Tray (A4310)	

FREQUENCY

☐	1 per day/ 30 per month	☐	5 per day/ 150 per month
☐	2 per day/ 60 per month	☐	6 per day/ 180 per month
☐	3 per day/ 90 per month	☐	7 per day/ 210 per month
☐	4 per day/ 120 per month	☐	Other ____ per day ____ per month

OTHER PRODUCT TYPES, SIZES and QUANTITIES

☐	Male External (A4349) Size: _____mm	☐	35 per month	☐	Other ____ per day
☐	Leg Bags (A4358)	☐	2 per month	☐	Other ____ per day
☐	Drainage Bags (A4357) Other: _____	☐	2 per month	☐	Other ____ per day
☐	Other: _____			☐	Quantity Per Month: _____

PRESCRIBING PHYSICIAN INFORMATION

Name & Credentials _____ NPI _____

Signature _____ Signature Date _____

(Stamped signature not accepted)

Phone _____ Fax _____