

PHYSICIAN'S ORDER-OSTOMY SUPPLIES

Patient's Name: (Last Name) \_\_\_\_\_, (First Name) \_\_\_\_\_, (M.I.) \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this patient currently being seen by Home Health?  Yes  No

PLEASE ATTACH PATIENT DEMOGRAPHICS

Name of Facility: \_\_\_\_\_ Name of Person ordering: \_\_\_\_\_

Expected Duration of Need \_\_\_\_\_ (Months)

- Diagnosis Codes:  V44.2 Ileostomy Status  V55.2 Attention to Ileostomy  Other \_\_\_\_\_
 V44.3 Colostomy Status  V55.3 Attention to Colostomy
 V44.6 Urostomy Status  V55.6 attention to Urostomy

Table with 4 columns: Product Description, HCPC Code, Manufacture Re-Order #, QTY. Multiple empty rows for data entry.

Physician's Name: \_\_\_\_\_
Telephone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
NPI #: \_\_\_\_\_
Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Assignment of Benefits: I request that payment of insurance of benefits be made on my behalf to Preston Wound Care, and/or any of its corporate affiliates for any medical supplies and/or medications furnished to me by PRESTON WOUND CARE. I authorized any holder of medical information about me to release to PRESTON WOUND CARE, my physician(s), caregiver, CMS its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which for I am responsible.
If another service provider is identified who can process this claim, I authorize PRESTON WOUND CARE to forward my medical records and advise the medical professionals in my care.
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_