ph: ***888-61-WOUND(96863)***

Prestonwoundcare

fax: ***866-509-9160***

PHYSICIAN'S ORDER- UROLOGICAL 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:

☐ 788.30 Permanent Urinary	☐ 344.6 Neurogenic Bladder	☐ 344.1 Paraplegia
☐ 788.20 Urinary Retention	☐ 340. Multiple Sclerosis	☐ 344.0 Quadriplegia
☐ 599.6 Urinary Obstruction	☐ 741 Spina Bifida	☐ Other_____

Product Description	HCPC Code	Manufacture Re-Order #	QTY

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: _____