STAR DME
Medical & Surgical Supply

Star DME Inc.
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Incontinence Supplies

NY MEDICAID · FISCAL ORDER

Written order for a 30-day supply. Fax this order with the patient's most recent visit note to **844-438-5893**.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Medicaid CIN _____ **Age** _____ **Weight** _____ lbs **Waist** _____ in **Hip** _____ in

Diagnosis

a specific ICD-10 code is required; check all that apply

URINARY

- ☐ **N39.3** Stress incontinence
- ☐ **N39.41** Urge incontinence
- ☐ **N39.45** Continuous leakage
- ☐ **N39.46** Mixed incontinence
- ☐ **N39.490** Overflow incontinence
- ☐ **R39.81** Functional incontinence

FECAL

- ☐ **R15.9** Full incontinence of feces
- ☐ **R15.0** Incomplete defecation
- ☐ **R15.1** Fecal smearing
- ☐ **R15.2** Fecal urgency

Other ICD-10 _____ **Cause of incontinence** _____

Supplies Ordered

per 30 days

ITEM	CHANGES PER DAY	QTY / 30 DAYS
☐ **Disposable briefs / pull-ons** — one size: ADULT ☐ S T4521 ☐ M T4522 ☐ L T4523 ☐ XL T4524 ☐ Above XL T4543	_____	_____ max 250 combined with liners
☐ **T4535** Disposable liners / shields / guards	_____	_____
☐ **A4554** Disposable underpads (Chux), all sizes **Covered with:** N39.3 (female), N39.41, N39.42, N39.45, N39.46, R39.81, R15.0, R15.2, R15.9 **Not covered with:** N39.3 (male), N39.43, N39.44, N39.490, R15.1	_____	_____ max 150

Start date _____ **Length of need** ☐ **12 months** ☐ **Lifetime (99)** **Refills** _____

Documented in the Chart

Check only what the practitioner's own visit note shows. The record must support the type and quantity ordered.

- ☐ Type of incontinence and its medical cause (e.g. stroke, SCI, dementia)
- ☐ Changes needed per day and why, supporting the quantity
- ☐ Current weight, waist and hip, supporting the size
- ☐ Underpads: why bed, chair or wheelchair protection is needed

Above 250 briefs/liners or 150 underpads needs prior approval with documentation of a condition causing increased urine or stool output.

Practitioner

Signature _____ **Date** _____

Printed name _____ **NPI** _____ **Phone / Fax** _____

Signature and date stamps are not acceptable. This form does not replace the practitioner's own medical record.