847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Incontinent Order Form

Referral Source:_____ Referral Source Phone:(_____)_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

INSURANCE INFORMATION

Medicare Number:___ NOT COVERED_____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy:_____

PRODUCT(S) REQUESTED

[ ] Diapers (200 Max) Times per day:____ Size: SM_____ MD_____ LG_____ XL_____ XXL_____

[ ] Pull-ups (200 Max) Times per day:____ Size: SM_____ MD_____ LG_____ XL_____ XXL_____

[ ] Panty liners (120 Max) Times per day:____ Size: SM_____ MD_____ LG_____

[ ] Underpads (150 Max) Times per day:_____

[ ] Gloves (200 Max) MD_____ LG_____ XL_____

[ ] Wipes (Allowed 50 per MONTH

Length of Need_____ (12mouths max)

PHYICIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____