Ostomy Supplies Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to the Ostomy coverage criteria sheet for all required documentation.

OSTOMY:

Date of Last Visit: _____

Length of Need (# of months) _____ 1-99 (99=lifetime)

Diagnosis and Code:

☐ Ileostomy (Z93.2) ☐ Attention to Ileostomy (Z43.2) ☐ Colostomy (Z93.3) ☐ Attention to Colostomy (Z43.3)
☐ Urostomy (Z93.6) ☐ Attention to Urostomy (Z43.6) ☐ Other: _____

Pouches:

Ostomy Pouches _____ each/monthly ☐ 1 Piece System ☐ 2 Piece System ☐ Clear ☐ Opaque
Please Select: ☐ Drainable Pouch ☐ Closed End Pouch

Wafers (Barrier):

Wafers _____/monthly (box amounts are not valid) ☐ with flange Stoma Size: _____
Please Select: ☐ Cut to Fit ☐ Precut ☐ Stomahesive ☐ Durahesive ☐ Flexible ☐ Solid

Monthly Supplies: (box amounts are not valid)

☐ Deodorant, (A4394) 8oz/month Other Qty _____
☐ Stomahesive Powder (A4371) 10oz/every 6mo Other Qty _____
☐ Stomahesive Paste Tube (A4406) 4oz/mo Other Qty _____
☐ Barrier Ring Flat, (A4385) 10/mo Other Qty _____
☐ Barrier Ring, Convex (A4411) 10/mo Other Qty _____
☐ Barrier Wipes (A5120) 150/6mo Other Qty _____
☐ Adhesive Remover (A4456) 200/mo Other Qty _____
☐ Tail closure/clamps (A4363) _____/mo Other Qty _____
☐ Skin Barrier, Solid 4x4 (A4362) 20/mo Other Qty _____
☐ Ostomy Belt (A4367) Other Qty _____

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____