Urological 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 Urological coverage criteria sheet for all required documentation.

UROLOGICAL SUPPLIES:

Date of Last Visit: _____ Length of Need (# of months) _____ 1-99 (99=lifetime)

Diagnosis and Code:

☐ R32 Urinary Incontinence
☐ R33.9 Urinary Retention, Unspecified
☐ Other: _____

Catheter Type:

☐ Intermittent (A4351-A4352) ☐ Foley (Indwelling) (A4311-A4316, A4338-A4346) _____/mo
☐ Sterile Catheter Kit (A4353) ☐ External Male (A4326, A4349) _____ mm

Daily Qty: _____ **Monthly Qty:** _____ **Tip Style:** ☐ Straight ☐ Coude

French Size: ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18 ☐ 20 ☐ 22 ☐ 24 ☐ Hydrophilic coating (additional criteria required)

Monthly Supplies:

☐ Leg/Abdominal Drainage Bag (A4357) 2/mo Other Qty: _____
☐ Overnight Drainage Bag (A4357) 2/mo Other Qty: _____
☐ Sterile Lubricant Pack (A4332) 1 per catheter change Other Qty: _____
☐ Insertion Tray (A4310) 1 tray per catheter change Other Qty: _____
☐ Extension Tubing (A4331) 2/mo Other Qty: _____
☐ Syringe (A4322) 4/mo Other Qty: _____
☐ Anchoring Device (A4333) 12/mo 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: _____