

PHYSICIAN ORDER FOR INCONTINENCE SUPPLIES

Ages 21 and above (Diapers, Pull-Ons, Liners, Under pads, Wipes and Non-Sterile Gloves)



OKLAHOMA
Health Care Authority

Initial Request _____ Amendment _____ Recertification _____

TO BE COMPLETED BY PHYSICIAN

SECTION I – PHYSICIAN INFORMATION	
<i>Ordering Physician MUST be SoonerCare Contracted</i>	
Printed name:	_____
Provider ID or NPI:	_____
Contact name:	_____
Phone number:	_____

SECTION II – MEMBER INFORMATION	
Name:	_____
Member ID:	_____
Date of birth:	_____
Address:	_____
Phone number:	_____

SECTION III	
Weight: _____ (lbs)	Type of incontinence: Urinary _____ Bowel _____ Both _____
Sex : M _____ F _____	Expected length of need: Months _____ OR Lifetime _____

SECTION IV	
INCONTINENCE DIAGNOSIS CODES: _____	
MEDICAL DIAGNOSIS CODES (which relates to incontinence): _____	

SECTION V – MOBILITY	
Ambulatory w/o assistance	_____
Ambulatory w/assistance	_____
Non Ambulatory	_____

SECTION VI - COGNITIVE FUNCTION	
<i>(Related to toileting needs, see www.okhca.org/mau, Incontinence Supplies, for info.)</i>	
Able to communicate needs (verbal or non-verbal)	_____
Unable to communicate needs	_____

SECTION VII - ABSORBENT PRODUCTS ORDERED (MUST BE A NUMBER)	
Diapers: _____ #/month	Liners/Shields: _____ #/month
Pull-ons: _____ #/month	Under pads (Disposable): _____ #/month
Under pads (Reusable): Chair _____ #/month	Bed _____ #/month
Under pads (Disposable): _____ #/month	Wipes: _____ #/month
Non-Sterile Gloves (100 per box) _____ #boxes/month	

SECTION VIII	
PHYSICIAN SIGNATURE: _____	DATE: _____

DME SUPPLIER PRIOR AUTHORIZATION REQUEST SECTION

TO BE COMPLETED BY CONTRACTED DME PROVIDER

PA # _____

DME Supplier:	Phone #:	Date Span Of Service	From:	To:
DME Provider ID:	Assignment Code: 12 – DME			

Line Item	HCPCS Code	Description (Must Be On One Line Item)	Total Units for Date Span
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			