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- NC Medicaid Alliance Trillium/CC
- Amerihealth VayaHealth Other:
- WellCare Partners/CC Healthy Blue
- UHC Carolina Complete

Incontinence Supplies Order Form

PATIENT INFORMATION -

Medicaid ID# _____
 Patient Name: _____ Date of Birth: _____
 Address: _____
 City: _____ Zip Code: _____ Phone #: _____

***Please attach faxesheetw/patient demographics&insuranceinfo**
 Please attach lab work, clinical notes and/or any other relevant documentation*

PRIMARY DIAGNOSIS	
<input type="checkbox"/>	R32 Urinary Incontinence
<input type="checkbox"/>	R15.9 Fecal Incontinence

NC Medicaid Primary or Secondary policies will typically cover incontinence supplies. Medicaid recipients under 3 years of age are NOT eligible for incontinence supplies.

BRIEFS/DIAPERS (max. 192-200/month)	
<i>specify</i>	
<input type="checkbox"/>	T4521 SMALL 20"-33"
<input type="checkbox"/>	T4522 MEDIUM 32"-42"
<input type="checkbox"/>	T4522 REGULAR 40"-50"
<input type="checkbox"/>	T4523 LARGE 48"-58"
<input type="checkbox"/>	T4524 XLARGE 57"-66"
<input type="checkbox"/>	T4543 XXLARGE 60"-69"

PULL UPS (max. 192-200/month)	
<i>specify</i>	
<input type="checkbox"/>	T4525 SMALL 20"-28"
<input type="checkbox"/>	T4526 MEDIUM 28"-40"
<input type="checkbox"/>	T4527 LARGE 40"-56"
<input type="checkbox"/>	T4528 XLARGE 56"-68"
<input type="checkbox"/>	T4544 XXLARGE 68"-80"

SECONDARY *A secondary diagnosis that contributes to the patient's incontinence is typically required			
<input type="checkbox"/>	F84.0 Autism	<input type="checkbox"/>	F84.9 Developmental Delay
<input type="checkbox"/>	G80.9 Cerebral Palsy	<input type="checkbox"/>	Q90.9 Down Syndrome
<input type="checkbox"/>	F03.90 Dementia	<input type="checkbox"/>	R39.81 Functional Incontinence
<input type="checkbox"/>	E11.9 Diabetes Mellitus	<input type="checkbox"/>	N39.44 Nocturnal Enuresis
<input type="checkbox"/>	Other:		

PEDS & YOUTH (max. 192-200/month)	
<i>specify</i>	
<input type="checkbox"/>	T4529 Diaper S & M
<input type="checkbox"/>	T4530 Diaper Lg & X-Lg
<input type="checkbox"/>	T4531 Pull-Ups S & M
<input type="checkbox"/>	T4532 Pull-Ups Lg & X-Lg
<input type="checkbox"/>	T4533 Diapers Youth
<input type="checkbox"/>	T4534 Pull-Ups Youth

<i>miscellaneous continence products</i>	
<input type="checkbox"/>	A4927 GLOVES 100 per bx <i>max 4/mo</i>
<input type="checkbox"/>	A4554 UNDERPADS/CHUX <i>max 150/mo</i>
<input type="checkbox"/>	A4335 MISC INCONTINENCE

Other DME Orders: _____

Start Date: _____ Stop Date _____ Length of need (99mon = Lifetime) _____

ORDERING PROVIDER INFORMATION Practice Address _____
 Physician Name: _____ NPI: _____
 Physician Signature: _____ Date: _____
 Physician Phone #: _____ Fax #: _____

*****Signature and/or Date stamps are not acceptable and will not qualify*****