Community Medical Supply

QUICK START PROGRAM

NEXT DAY DELIVERY

"Let Us Cover It"

CMN Order
Fax: 888.412.7605
Questions Please Call: 888.688.6149

Full Assignment Accepted

PATIENT NAME: ______________________ DATE: __________

NAME OF CLINIC: ______________________ CITY: __________ PHONE: __________

In order for Community Medical to process your/a patient's order, we need the following documentation faxed:
*Copy of the **PATIENT FACE SHEET** *signed (**AOB**) (at bottom) ***ORDER SIGNED BY PHYSICIAN**

OSTOMY SUPPLIES

	Item	Product	Allowable	Use
		Drainable Pouches	20 Per Month	1 Every 1 to 2 Days for 12 Months
		Closed Pouches	60 Per Month	2 Per Day for 12 Months
		Barriers	20 EA	Every Barrier Change for 12 Months
		Paste (per ounce)	4oz	Every Barrier Change for 12 Months
		Adhesive Remover (wipe 50bx)	3 Every 6 Months	Every Barrier Change for 12 Months
		Ostomy Belt	1 Per Month	1 Every 30 Days
		Ostomy Deodorant	8oz	Every Time Pouch is Emptied for 12 Months
		Inserts	10 Per Month	1 Every 30 Days
		Tape	2; 1" rolls	1 Every 3 Days for 12 Months
		Skin Prep Wipes	50 Every 2 Month	Every Time Barrier is Applied for12 Months
		Night Bags	2 Per Month	1 Every 2 Weeks for 12 Months
		Leg Bags	2 Per Month	1 Every 2 Weeks for 12 Months

PATIENT HAS BEEN TRAINED ON HOW TO USE PRODUCT:
YES NO

PATIENT IS ON HOME HEALTH?

ANTICIPATED HH DC DATE:

PLEASE PROVIDE EMAIL FOR ELECTRONIC SIGANURE IF PROVIDER IS UNBALE TO SIGN: ______________________

Prognosis:	
Diagnosis:	
Length of Need:	

PROVIDER: ______________________ FAX: ______________________

NPI: ______________________ PHONE: ______________________

PHYSICIAN SIGNATURE: ______________________ DATE: __________

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Community Medical Supply for any supplies or services furnished to be by Community Medical Supply. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to Community Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Community Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S NAME: __________ DATE OF BIRTH: __________ SOCIAL SECURITY NO: __________

ADDRESS: ______________________ PHONE: __________

PRIMARY: __________ ID: __________ DATE: __________

SECONDARY: __________ ID: __________ SIGNATURE: __________

NOTES: