Community Medical Supply

Quick Start Program
Urology

CMN Order
Fax: 888-412-7605
Order Questions: 888-688-6149
Full Assignment accepted

Patient Name: _____ Date: _____

Name of Clinic: _____ Phone: _____

Product	Type	French Size	Qty/Mo
Intermitten Catheter - Hydrophilic	☐Straight ☐Coude	☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20	
Intermitten Catheter	☐Straight ☐Coude	☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20	
Intermitten Catheter Kit	☐Straight ☐Coude	☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20	
Male External Catheter	S☐M ☐Int ☐L ☐XL		
Foley Catheter w/ insertion tray	☐10cc ☐30cc	☐8 ☐10 ☐12 ☐14 ☐16 ☐18 ☐20	
Urinary Leg Bag	☐S ☐M ☐L		
Bedside Drainage Bag 2000cc			
Lubricant	☐Individual ☐Bottle		
Other			

ICD-10 Diagnosis: Urinary Incont. R32 Neuro. Bladder N31.9 Urinary Reten. R33.9

Other: _____

Does patient have a latex allergy? ***Yes*** ***No***

Does patient have UTI history? ***Yes*** ***No***

Length of need: Lifetime unless otherwise noted Other:

*Copy of the patients face sheet *signed (AOB at bottom) *ORDER SIGNED BY HEALTH CARE PROVIDER*

Providers Name: _____ ***NPI:*** _____

Providers 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. I ACKNOWLEDGE THAT I HAVE RECEIVED THE POLICIES AND PROCEDURES AND HIPPA INFORMATION FROM COMMUNITY MEDICAL

Patient Name: _____

Patient Signature: _____ ***Date:*** _____