LNS MEDICAL SUPPLY

WE CARE ABOUT YOUR HEALTH!

Fax: 1-888-251-0202

Phone: 1-800-720-2830

PATIENT ORDER FORM

Catheter Order Form

PATIENT SECTION			
Patient Name:		**Start Date:**	
Gender:		**Date of Birth:**	
Primary E-mail:		**Mobile Number:**	
Shipping Address:		**Home Number:**	
		Work Number:	

PHYSICIAN SECTION

Step 1: Diagnosis Code (required):

☐ **R33.9 Retention of Urine** ☐ **R32 Urinary Incontinence** ☐ **Other: _______** ☐ **Other: _______** ☐ **Other: _______**

HCPCS	Frequency / Quantity
☐ **A4351 Straight Catheter**	☐ **1 per day / 30 per month / 90 per 3 months**
☐ **A4332 Packets of Lube**	☐ **2 per day / 60 per month / 180 per 3 months**
	☐ **3 per day / 90 per month / 270 per 3 months**
☐ **A4352 Coude Catheter**	☐ **4 per day / 120 per month / 360 per 3 months**
☐ **A4332 Packets of Lube**	☐ **5 per day / 150 per month / 450 per 3 months**
	☐ **6 per day / 180 per month / 540 per 3 months**
☐ **A4353 Closed Kit**	☐ **7 per day / 200 per month / 600 per 3 months**
	☐ **___ per day / ___ per month / ___ per 3 months**
☐ **A4402 Tube of Lubricant**	☐ **4 oz per month / 12 oz per months**

Authorizing 99 refills. If otherwise, please specify: ___________________. (Cannot be PRN.)

The above information is true, accurate, and complete to the best of my knowledge. I confirm that the patient is/was treated by me, and is able to use the supplies prescribed. I verify that the patient's medical condition requires the supplies prescribed and that the usage quantities are medically necessary. I will maintain a copy of this order in the patient's file.

Physician Name:	**NPI #:**	**Phone Number:**	
Office Address:		**Fax Number:**	
PRESCRIBER SIGNATURE		**DATE**	

*****NO STAMP ON SIGNATURE LINE*****

WEB