

LNS MEDICAL SUPPLY

WE CARE ABOUT YOUR HEALTH!

Fax: 1-888-251-0202

Phone: 1-800-720-2830

PATIENT ORDER FORM Ostomy 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):

Z43.3 Colostomy Z43.2 Ileostomy Z43.6 Urostomy Other: _____

<input checked="" type="checkbox"/> A4425 Drainable Pouch (20 per month / 60 per 3 months)	<input checked="" type="checkbox"/> A4419 Closed Pouch (60 per month / 180 per 3 months)
<input checked="" type="checkbox"/> A5057 One Piece Drainable Pouch (20 per month / 60 per 3 months)	<input checked="" type="checkbox"/> A4407 Skin Barrier Wafer/Flange (20 per month / 60 per 3 months)
<input checked="" type="checkbox"/> A4362 Skin Barrier Strips (20 per month / 60 per 3 months)	<input checked="" type="checkbox"/> A4409 Skin Barrier Wafer/Flange (20 per month / 60 per 3 months)
<input checked="" type="checkbox"/> A4406 Ostomy Paste (2 oz per month / 6 oz per 3 months)	<input checked="" type="checkbox"/> A4385 Skin Barrier Rings (20 per month / 60 per 3 months)
<input checked="" type="checkbox"/> A4394 Ostomy Deodorant (8 oz per month / 24 oz per 3 months)	<input checked="" type="checkbox"/> A4371 Ostomy Powder (1 oz per month / 5 oz per 3 months / 10 oz per 6 months)
<input checked="" type="checkbox"/> A5120 Proctective Skin Barrier Wipes (25 per month / 75 per 3 months / 150 per 6 months)	<input checked="" type="checkbox"/> A4456 Adhesive Remover Wipes (50 per month / 150 per 3 months)
<input checked="" type="checkbox"/> A4367 Ostomy Belt (1 per month / 3 per 3 months)	<input checked="" type="checkbox"/> A4455 Medical Adhesive Remover Spray (2 oz per month / 8 oz per 3 months / 16 oz per 6 months)
<input checked="" type="checkbox"/> A4369 Ostomy Skin Barrier, Liquid (Spray, Brush, etc) (2 oz per month / 6 oz per 3 months)	<input checked="" type="checkbox"/> A4396 Ostomy Support Belt (2 per 6 months / 4 per 12 months)
<input checked="" type="checkbox"/> A6216 Gauze (60 per month / 180 per 3 months)	<input checked="" type="checkbox"/> A4404 Sure Seal Ring (10 per month / 30 per 3 months)
<input checked="" type="checkbox"/> A4364 Medical Adhesive Spray (4 oz per month / 12 oz per 3 months)	<input checked="" type="checkbox"/> A4452 Ostomy Tape (40 yards per month / 120 yards per 3 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