

# Urology Supply Order Form

Please Include Patient Demographics Page



P: (301) 855-8199 F: (301) 855-3448  
www.bay-med.com

### Fax or Email Orders for Processing:

Email to: mail@bay-med.com or \_\_\_\_\_  
Fax to: (301) 855-3448

### Ordering Office Contact:

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

### Step 1: Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### Step 2: Insurance

Primary: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_ Phone: \_\_\_\_\_

### Step 3: Diagnosis

Primary:  Z87.440 Personal History of UTI  D84.822 Immunodeficiency  
 R32 Urinary Incontinence  G82.50 Quadriplegia  G82.20 Paraplegia  
 R33.9 Retention of Urine  Z93.6 Urostomy  Q05.9 Spina Bifida  
 N31.9 Neurogenic Bladder  G35 Multiple Sclerosis  Other: \_\_\_\_\_

Secondary: \_\_\_\_\_

### Step 4: Dispensing

Start Date: \_\_\_\_\_  
Duration:  
 99 (lifetime)  
 12 months  
 Other: \_\_\_\_\_ Months

### Step 5: Recommended Supplies

Intermittent Catheters	Brand/Item	French Size	Frequency per Day (Required)	
<input type="checkbox"/> Intermittent Urinary Catheter (A4351)		<input type="checkbox"/> 8 FR	<input type="checkbox"/> 3 per day/90 month/270 per 3 months	
<input type="checkbox"/> Intermittent Urinary Catheter: Coude Tip (A4352)		<input type="checkbox"/> 10 FR	<input type="checkbox"/> 4 per day/120 month/360 per 3 months	
<input type="checkbox"/> Intermittent Urinary Catheter with Insertion Supplies (A4353) <input type="checkbox"/> Straight <input type="checkbox"/> Coude Tip		<input type="checkbox"/> 12 FR	<input type="checkbox"/> 5 per day/150 month/450 per 3 months	
		<input type="checkbox"/> 14 FR	<input type="checkbox"/> 6 per day/180 month/540 per 3 months	
		<input type="checkbox"/> 16 FR	<input type="checkbox"/> 7 per day/210 month/630 per 3 months	
		Other _____	<input type="checkbox"/> Other _____	
Urological Items	Brand/Item	French Size	Quantity/Month	Frequency of Use
Male External Catheters				
Leg Bag				
Foley Catheter <input type="checkbox"/> Two-way <input type="checkbox"/> Three-Way <input type="checkbox"/> Latex <input type="checkbox"/> Silicone				
Foley Insertion Trays <input type="checkbox"/> w/bag <input type="checkbox"/> w/o bag				
Lubricant <input type="checkbox"/> packets <input type="checkbox"/> tube				
Other				
Incontinence Items	Size/Type	Quantity/Month	Frequency of Use	
<input type="checkbox"/> Briefs <input type="checkbox"/> Pullups <input type="checkbox"/> Liners				
<input type="checkbox"/> Other: _____				

### Step 6: Prescribers Information

Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DISPENSE AS WRITTEN