



**Piedmont Medical Solutions, Inc.**  
**2255 Lewisville Clemmons Road, Suite F**  
**Clemmons, NC 27012**  
**Office: 336-602-1668 Fax: 866-211-2286**

Order Date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Initial ☐ Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Length of Need: **99 months / lifetime**

Diagnosis: ☐ R33.9 - Urinary Retention ☐ R32 - Urinary Incontinence ☐ Other: \_\_\_\_\_

The patient's condition is a permanent condition and will persist for 3 months or greater? ☐ Yes ☐ No

Equipment: Urinary Supplies

Quantity:

Size:

- |   |             |             |
|---|-------------|-------------|
| <input type="checkbox"/> A4351 Intermittent Urinary Catheters, Straight Tip                       | _____/month | ____ French |
| <input type="checkbox"/> Ultra Plus (female only) <input type="checkbox"/> GC Air (hydrophilic)   |             |             |
| <input type="checkbox"/> A4352 Intermittent Urinary Catheters, Coude Tip                          | _____/month | ____ French |
| <input type="checkbox"/> GC Air (hydrophilic)   |             |             |
| <input type="checkbox"/> A4353 Intermittent Urinary Catheters, Closed System Kit w/collection bag | _____/month | ____ French |
| <input type="checkbox"/> Dextra (straight tip only)   |             |             |
| <input type="checkbox"/> A4338 Foley Catheter   | _____/month | ____ French |
| <input type="checkbox"/> A4338 Supra-Pubic Catheter (up to size 24 French)                        | _____/month | ____ French |
| <input type="checkbox"/> A4310 Insertion Tray   | _____/month |             |
| <input type="checkbox"/> A4402 Lubricant for Urinary Catheter insertion – 4 oz. tube              | _____/month |             |
| <input type="checkbox"/> A4332 Lubricant, Individual Sterile Packet, Each                         | _____/month |             |
| <input type="checkbox"/> A4349 Male External Catheters  | _____/month |             |
| <input type="checkbox"/> A4357 Bedside Urinary Drainage Bag                                       | _____/month |             |
| <input type="checkbox"/> A4358 Leg or Abdomen Urinary Drainage Bag, vinyl                         | _____/month |             |

Medicaid **ONLY** Items:

- |  |             |             |
|--|-------------|-------------|
| <input type="checkbox"/> A4520- T_____ Pullups, Diapers/Briefs Size: _____ | _____/month |             |
| <input type="checkbox"/> A4554 Underpads                                   | _____/month |             |
| <input type="checkbox"/> A4927 Exam Gloves                                 | _____/month |             |
| <input type="checkbox"/> A_____ Wipes                                      |             |             |
| <input type="checkbox"/> Other: _____                                      | _____/month | ____ French |

**Frequency of Change:** \_\_\_\_\_/Day

Provider Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

Provider NPI #: \_\_\_\_\_



We honor those women who have been diagnosed with Ovarian Cancer and the valiant battle they fight every day – past and present - with an ongoing 5% donation of monthly Catheter revenues to the Forsyth Medical Center Foundation GYN Cancer Fund.

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

Fax this form to 866-211-2286 with the following: 1. Clinical notes with diagnosis 2. Patient Demographics 3. Copy of patient insurance card

Visit us at: [www.piedmontmedicalsolutions.com](http://www.piedmontmedicalsolutions.com)