Physician's Choice DME

1627 S. Central Ave., Glendale CA 91204 Tel: (805) 409-0600 Fax: (805) 497-0905

Medical Supplies Prescription Form

Patient's Name: _____

Address: _____

_____

Telephone #: _____

Medi-Cal ID#: _____

Health Plan ID# _____

Date of Birth _____ Age: _____

Patient is incontinent of: Bladder Bowel Both

Type of Urinary Incontinence: Overflow Stress Urge Mixed Functional

Type of Bowel Incontinence: Nervous system pathology Functional (i.e. chronic constipation)

Medical condition/diagnosis causing bowel or bladder incontinence:

1. DX _____ ICD10 _____
2. DX _____ ICD10 _____

HCPCS Code	Description

Prescribing Physician's Verification

I have reviewed my patient's records and the items requested above. I verify that I have physically examined the patient within the last twelve months, and have established that this patient has chronic pathologic condition that is casually related to clinical diagnosis. I authorize the items described above as medically necessary for the recipient. I will maintain a copy of this prescription in the recipient's medical record to meet Medi-Cal documentation requirements.

Physician's NPI/State ID Number **Physician's Telephone:** **Fax:** _____

Physician's Name & Address _____

Date : **Physician's Signature :** _____