HANDI MEDICAL SUPPLY

Standard Written Order: Incontinence

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

☐ N39.46 Mixed incontinence ☐ R15.9 Full incontinence of feces ☐ R32 Unspecified urinary incontinence

☐ Other:

Patient Height: **Patient weight:**

Product	Size	Dispensing Quantity	Frequency of Change
Disposable Briefs with Tabs/Diapers	☐ Adult Small (T4521)		
	☐ Adult Medium (T4522)		
	☐ Adult Large (T4523)		
	☐ Adult X-Large (T4524)		
	☐ Adult XX-Large (T4543)		
	☐ Pediatric Small/Medium (T4529)		
	☐ Pediatric Large (T4530)		
	☐ Youth (T4533)		
Disposable Underwear/ Pull-ons	☐ Adult Small (T4525)		
	☐ Adult Medium (T4526)		
	☐ Adult Large (T4527)		
	☐ Adult X-Large (T4528)		
	☐ Adult XX-Large (T4544)		
	☐ Pediatric Small/Medium (T4531)		
	☐ Pediatric Large (T4532)		
	☐ Youth (T4534)		
Liner/Shields	☐ Liner/Shields (T4535)		
Under Pads	☐ Disposable Large (T4541)		
	☐ Disposable Small (T4542)		
	☐ Reusable (T4537)		

1. **Ordered Date:** _____ 2. **Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. **Please attach medical records supporting necessity of the above ordered item(s).**

4. _____ _____

Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: NPI:

Fax back: **651-644-0602** **www.handimedical.com**

 Form: 0745-20220112 **Tel: 651-644-9770 or 800-514-9979** 2505 University Avenue West, St. Paul, MN 55114