SAGE MEDICAL SUPPLY

OSTOMY ORDER FORM

Phone: 484.364.3039 • Fax: 610.471.0791

In order to process your patient's order we need the following documentation faxed along with this completed form:
PATIENT DEMOGRAPHICS - (Insurance & Physical Address)

REFERRING FACILITY

Name:

City: State:

Phone:

Fax:

CASE MANAGER

NOTES

PATIENT INFORMATION

RX Date:

Patient's Name:

Is the patient currently being seen by Home Health Services? ❑ Yes ❑ No

Is the patient allergic to latex? ❑ Yes ❑ No

Has the patient been instructed on the use of the requested supplies? ❑ Yes ❑ No

✔	DIAGNOSIS
❑	
❑	
❑	
❑	

STOMA SIZE

✔	ESTIMATED TIME OF NEED
❑	99 = LIFETIME
❑	OTHER:

ITEM	BRAND/PART#	FREQUENCY OF USE	QUANTITY TO DISPENSE
OSTOMY POUCH - ONE PIECE			
OSTOMY POUCH - TWO PIECE			
FLANGE WITH SKIN BARRIER			
SKIN BARRIER PASTE			
SKIN BARRIER POWDER			
SKIN BARRIER WAFER (SOLID) SIZE:			
URINARY DRAINAGE BAG TYPE:			
ADHESIVE REMOVER WIPES			
SKIN PREP WIPES			
TAPE TYPE:			
OTHER:			

PROVIDERS APPROVAL

Print Name:

NPI#

SIGNATURE **DATE:**

* I attest by my signature that: 1) the requested supplies are medically necessary and it is my intention for this prescription to remain valid until the underlying disease/diagnosis described above is resolved, or otherwise directed by the signer, 2) the patient has been instructed on the specific use of the requested supplies and is competent to use them, and 3) the supplier should provide the requested supplies in 3 month intervals pursuant to the associated Local Coverage Determination for Ostomy Supplies, unless otherwise indicated.

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Sage Medical Supply for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to Sage Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Sage Medical to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S SIGNATURE