PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: ______________________ Date of birth: __________ Age: __________

Medicaid ID: ______________________ Height: __________ Weight __________

Recipient's Address ______________________

Prescribing Provider:

Prescriber's Name: ______________________ Phone #: __________

Address: ______________________ Fax # __________

- **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD CM code):**

  Primary: __________ **Secondary:** __________

- **Specify Urine/Fecal incontinence diagnoses (Specify ICD CM code):**

  Primary: __________ **Secondary:** __________

- **Mobility**
  - ☐ Ambulatory
  - ☐ Transfer Assistance
  - ☐ Minimal assistance ambulating
  - ☐ Confined to bed or chair

- **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
  Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

- **Mental Status/Level of Orientation**
  - ☐ Has the ability to communicate needs
  - ☐ Sometimes communicates needs
  - ☐ Unable to communicate needs

  Frequency of anticipated change

  During Day time (6 AM-10PM) ________.
  During Night time (10PM – 6 AM) _______.

- **Additional supporting Diagnoses (Specific ICD-CM Code)**

  ____
  ____

  Indicate current supportive services
  - ☐ Home Health
  - ☐ Skilled Nursing Services
  - ☐ Personal Care Services
  - ☐ Other __________

- **List any medications and/or nutritional therapy that would increase urine or fecal output:**

  ____

- **Specify incontinence supply, size, quantity/24 hours and duration of need:**

				Qty per day	Size (S, M, L, XL)
☐ Diapers (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	______	______
☐ Pull-ups (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	______	______
☐ Liner/shield (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	______	______

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

____

Date:

____

- **Comments**

  ____
  ____
  ____
  ____
  ____

☐ Additional documentation attached

Diaper Program Information for Families

The Medicaid Diaper Program provides diapers and/or pull-ups for individuals between the ages of 4-20 years old.

When your child's physician completes the form, it is important that 3 main points are listed. These points include:

1. Under diagnosis, a code for urinary (788.30) and fecal (787.60) incontinence must be documented;
2. Under comments, it should state that the use is for a "lifetime need"; and
3. Under "Specify Incontinence Supply" it should list whether or not diapers or pull ups are needed, along with the recommended amount that will be used in a 24 hour period (Medicaid will pay for 6 diapers per 24 hour period unless the doctor writes down that more are needed and the reasons for those additional diapers).

In addition, if your child utilizes Pediasure or other dietary supplements, Medicaid may cover this as well. Simply obtain a prescription from your child's doctor that states his or her diagnosis, height, weight, number of cans used per day, and the number of refills authorized.

Once the form for the diapers is completed and/or the prescription for Pediasure is obtained from the doctor, please submit it to one of the following of your choice:

Hospital Drug Store
2716 Piedmont Street
Kenner, LA 70062
(504) 524-2254 Phone
(504) 528-9310 Fax

National Total Care Services, LLC
115 Marcon Drive
Lafayette, LA 70507
Linda Mouton – Local Representative
(337) 291-9919 Phone
(337) 291-9920 Fax
(877) 236-6687 Toll-Free
linda.totalcare@att.net
http://nationaltotalcare.com/

McKesson Patient Care Solutions (Diapers only)
540 Lindberg Dr.
Moontownship, PA 15108
Lauren Melzer – Local Representative
(504) 669-3092 Phone
(404) 609-2706 Fax
http://www.mckesson.com/

BHSF Form DIP1
Revised 10/15

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: ______________________ Date of birth: __________ Age: ________

Medicaid ID: ______________________ Height: __________ Weight ________

Recipient's Address ______________________

Prescribing Provider:

Prescriber's Name: ______________________ Phone #: ________

Address: ______________________ Fax # ________

➤ **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD CM code):**

Primary: Ask your MD for code

Secondary: ________

➤ **Specify Urine/Fecal incontinence diagnoses (Specify ICD CM code):**

always same → Primary: 788.30

Secondary: 787.6

➤ **Mobility**

- ☐ Ambulatory
- ☐ Transfer Assistance
- ☐ Minimal assistance ambulating
- ☐ Confined to bed or chair

➤ **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

(whichever applies)

➤ **Mental Status/Level of Orientation**

- ☐ Has the ability to communicate needs
- ☐ Sometimes communicates needs
- ☐ Unable to communicate needs

Frequency of anticipated change

During Day time (6 AM-10PM) ________.

During Night time (10PM – 6 AM) ________.

(can get up to 8 per day)

➤ **Additional supporting Diagnoses (Specific ICD-CM Code)**

____

____

Indicate current supportive services

- ☐ Home Health
- ☐ Skilled Nursing Services
- ☐ Personal Care Services
- ☐ Other ________

➤ **List any medications and/or nutritional therapy that would increase urine or fecal output:**

____

➤ **Specify incontinence supply, size, quantity/24 hours and duration of need:**

(Choose)

				Qty per day	Size (S, M, L, XL)
☐ Diapers (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	________	________
☐ Pull-ups (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	________	________
☐ Liner/shield (Check one):	[ ] child size	[ ]☐ youth-sized	[ ] adult-sized	________	________

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

____

Date:

____

➤ **Comments**

→ failed bowel and bladder training program

→ able to assist with pull-ups

☐ Additional documentation attached