PureWick® Collection System Prescription Form

Please attach PureWick® Collection System Supply Information, Insurance Card, Chart Notes and FAX to 1-800-372-6680

PATIENT INFORMATION

1

NAME (required) _____ DOB _____ Gender ☐ M ☐ F

Address _____ Spanish Speaking Only ☐

City, State, Zip _____ **PHONE** (required) _____

EMAIL _____

Primary Insurance _____ Policy ID# _____ Secondary Insurance _____ Policy ID# _____

2

Start Date: (required) _____

3

Length of Need: (required) ☐ Lifetime (99 months) or ☐ Months _____

4

Primary ICD-10 Diagnosis: (required)

- ☐ R32 Urinary incontinence, unspecified
- ☐ N39.41 Urge incontinence
- ☐ N39.42 Incontinence without sensory awareness
- ☐ N39.45 Continuous leakage
- ☐ N39.46 Mixed incontinence
- ☐ N39.3 Stress incontinence
- ☐ N39.44 Nocturnal enuresis
- ☐ N39.490 Oveflow Incontience
- ☐ N39.498 Other specified urinary incontinence
- ☐ N31.9 Neurogenic bladder
- ☐ Other _____

PUREWICK® SUPPLY INFORMATION

5

All four components are **required** at time of dispensing initial order. Any revisions must be initialed/date by Provider. Do not use whiteout; a single line strike will suffice.

	Description	HCPCS Code	Qty	Freq
☐	**PureWick® Urine Collection System** Suct pum ext mgmt sys	E2001	1	1x month
☐	**PureWick® External Catheters** Urinary cath disp suc pump	A6590	1	30x month
☐	**PureWick® 2000cc Collection Canister** Non-disposible pump canister	A7001	1	1x month
☐	**PureWick® Replacement Collector Tubing** Tubing used w/suction pump	A7002	1	1x month

SPECIAL INSTRUCTIONS:

_____

Please Print Here

CLINICIAN INFORMATION

6

My signature below denotes that to the best of my knowledge the patient/caregiver is capable of using the ordered items which are designed for home use and is informed that he/she will be contacted by telephone from BD and/or a medical equipment supplier regarding covered items ordered. The patient/caregiver has successfully completed training or is scheduled to begin training on the use of the supplies.

I understand these prescriptions will be directed to Liberator Medical Supply, Inc. for fulfillment unless patient, health care provider or insurance provider chooses another supplier. Liberator Medical Supply is a wholly owned subsidiary of BD.

CLINICIAN'S NAME (required) _____ License # _____ NPI _____

CLINICIAN'S SIGNATURE (required) _____ Credentials _____ **DATE** (required) _____

Institution _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

RN/MA Contact Name _____

Please consult product inserts and labels for any indications, contraindications, hazards, warnings, cautions and directions for use.

All prescribing decisions are at the discretion of the provider.

As a manufacturer, we cannot instruct a provider how to bill. We can only provide possible codes that may be appropriate for the products listed. The supplier of product must ascertain which codes are appropriate for the products provided and ensure supporting documentation is available in the patient's medical record as required.

Please attach PureWick® Collection System Supply Information, Insurance Card, Chart Notes and FAX to 1-800-372-6680

PH: 1-800-559-4109