Renew Insert Prescription

Physician Order

PLEASE ATTACH COVER PAGE AND FAX TO BEDARD AT 207-795-7622
PLEASE ALSO GIVE YOUR PATIENT A COPY OF THIS PRESCRIPTION FOR THEIR RECORDS

PATIENT INFORMATION		
Name:		Gender: ☐ M ☐ F
Date of birth:	SSN:	Phone:
Street address:		Email:
City, State, Zip:		
Primary Insurance: Phone number: Group: Patient ID:		Secondary Insurance: Phone number: Group: Patient ID:

PRESCRIBED RENEW INSERT PRODUCT		
☐ Starter Pack Ref 702 (5 Regular and 5 Large Inserts)	☐ Regular Ref 706 (Pack of 30 Regular Sized Inserts)	☐ Large Ref 707 (Pack of 30 Large Sized Inserts)

Check all three boxes above to allow patient to determine appropriate size of Insert on their own.
For HCPCS coding, use A4337 Incontinence supply, rectal insert, any type, each.

Frequency of need: _____ Renew Inserts/month Length of need: ☐ Indefinite ☐ _____ Years ☐ _____ Months Number of Refills: _____ Permanent Fecal Incontinence (90 days or greater): ☐ Yes ☐ No	ICD9 / ICD10 Diagnosis ☐ 787.60 / R15.9 Full incontinence of feces ☐ 787.61 / R15.0 Incomplete defecation ☐ 787.62 / R15.1 Fecal smearing ☐ 787.63 / R15.2 Fecal urgency ☐ _____ Other _____

Physician notes. Include previous treatments tried that have not provided adequate response for this patient.
Examples: ☐ dietary modification ☐ pharmacological ☐ strengthening exercises

PHYSICIAN INFORMATION	
I have reviewed the patient's medical records and the items requested above. I verify the patient's medical condition requires the supplies described and that the usage quantities are medically reasonable and necessary. I will maintain a copy of this prescription in the patient's file to comply with the carrier's requirements.	
Physician's name:	Physician's Tel:
Physician's address:	
NPI #:	License #:
RN/LPN Contact Name:	Email:
Physician's signature:	Date:

Bedard Medical Supplies 359 Minot Ave Auburn ME 04210
Tel: 866-623-3273 Email: orders@BedardMedical.com Encrypt emails containing patient information.