

How To Order: Please provide us with the following information and have your physician fill out and process the attached form. All information must be complete prior to shipment. **You can also call a patient support specialist at (866)506-7107 to assist with any questions. We will help you complete your order form, obtain your prescription and file your Medicare or insurance claim.**

1. Patient Information

Patient Name: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Medicare Policy Number: _____
Private Insurance Co.: _____ Plan/Group #: _____
Policy Number: _____ Phone: _____
Secondary Insurance Co.: _____ Plan/Group #: _____
Policy Number: _____ Phone: _____

2. Assignment of benefits

I authorize the equipment supplier, Uromatrix Medical Systems/Pos-T-Vac or Authorized Distributors, to file my insurance benefits and obtain medical records pertaining to this claim and assign payment of benefits to supplier. I understand the supplier will file my insurance as a courtesy only and not as a guarantee of unmet deductible or any amount not paid by my insurance claim as pre-authorized by my insurance company. My signature below is confirmation of the order I am placing.

Patient Signature: _____ Date: _____

3. Complete your product selection

- Liberty3.0** (Large Urinary Opening) _____ units/month for life (30 per month) (A4326)
 - Urinary Drainage Collection:** Bed Bag (A4357) 2 per month
- We have several accessories to help with incontinence. These items are not covered by Medicare. We will send you a separate invoice for these items.
- Cath Grip** \$20 **Free Derm** \$10 per box of 100 **Continance Control Device** \$40 per pack of 4 **Leg Bag** 5 for \$35

4. Have your physician complete the prescription form

Physician Information BioDerm Liberty3.0 Prescription Form **DO NOT SUBSTITUTE. DISPENSE AS WRITTEN**

The Patient experiences the following type of Urinary Incontinence: (check all that apply)

<input type="checkbox"/> Nocturnal Enuresis (788.36)	<input type="checkbox"/> Continuous Leakage (788.37)	<input type="checkbox"/> Post Void Dribbling (788.35)
<input type="checkbox"/> Stress Incontinence (788.32)	<input type="checkbox"/> Urinary Incontinence (788.30)	<input type="checkbox"/> Urge Incontinence (788.31)
<input type="checkbox"/> Mixed Stress Incontinence (788.33)	<input type="checkbox"/> Other Urinary Incontinence (788.39)	



The Patient's Urinary Incontinence is associated with the following condition: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Urinary Tract Injury (599.0) | <input type="checkbox"/> Decubitus Ulcers (707.0) | <input type="checkbox"/> Urinary Tract Infection (98.0) |
| <input type="checkbox"/> Carcinoma of the Prostate (185) | <input type="checkbox"/> Penile Shaft Wound (878.0) | <input type="checkbox"/> Penile Ulcer (607.89) <input type="checkbox"/> Other |

Use Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.
____ Patient has failed, has a contraindication or has intolerance to pharmacological therapy
____ There is documentation of Medical Notes Supporting Incontinence

Please supply notes with prescription.
Most recent date evaluated for the condition of Urinary Incontinence: _____

I certify the medical necessity of BioDerm Liberty3.0 as the required therapy for this patient. All other, less expensive means of collecting urine from this patient are not successful for the patient to maintain health. I am ordering this product for the patient as a reasonable and necessary treatment for his diagnosis.

Physician Name: _____ NPI #: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I certify that I am the physician identified in this form. I have reviewed the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in it is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed or will be trained on the proper use of products prescribed on this Written Order. The products lists and physician notes and other supporting documentation will be provided to Uromatrix Medical System, Post-T-Vac or authorized distributor upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. By faxing this form I am acknowledging that the patient is aware that Uromatrix and/or an authorized distributor may contact them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

Physicians Signature: _____ Date: _____

***Patient order cannot be completed until records specifying a diagnosis of incontinence are faxed to (888)352-4421.**

5. Send all completed information and copies of insurance cards (front & back) with the prescription to this address:

UroMatrix Medical • A Pos-T-Vac Company • 4811 Technology Drive • Martinez, GA 30907