bedard MEDICAL SUPPLIES

Renew Inserts Prescription Order Form

Please fax this form to Bedard Medical Supplies at 207-795-7622

Please include the *Patient Demographic Sheet*

Patient progress notes to support medical necessity are required in order for insurance to approve claim

1. Patient Information

Name:_____ DOB:_____ Gender: ☐ M ☐ F

Street Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

Primary Insurance Name:_____ ID #:_____

Group ID #:_____ Phone #:_____

Secondary Insurance Name:_____ ID #:_____

Group ID #:_____ Phone #:_____

3. Physician's Order

Product Selection (Check all three boxes below to allow patient to determine appropriate size of Insert on their own):

☐ Starter Pack (Ref 702) - Includes 5 Regular & 5 Large Inserts

☐ Regular (Ref 706) - Pack of 30 Regular Size Inserts

☐ Large (Ref 707) - Pack of 30 Large Size Inserts

Number of Refills:_____

Frequency of Need:_____(how many) Renew Inserts per month

Length of Need: ☐ Indefinite ☐ _____ Years ☐ _____ Months

Does patient have Permanent Fecal Incontinence (90 days or greater): ☐ YES ☐ NO

Physician Notes (Include previous treatments that have not provided an adequate response for patient):

Examples: ☐ Dietary Modification ☐ Pharmacological ☐ Strengthening Exercises

☐ Other:_____

4. Diagnosis Information

ICD-10 Code	Description
☐ R15.9	Full Incontinence of feces
☐ R15.0	Incomplete defecation
☐ R15.1	Fecal Smearing
☐ R15.2	Fecal Urgency
☐ Other:_____	Other:_____
☐ Other:_____	Other:_____

For HCPCS coding:
A4337
Incontinence Supply, Rectal Insert, Any Type, Each

5. Prescriber Information

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable.

Physician Name:_____ NPI #:_____

Phone #:_____ Fax #:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Physician Signature:_____ Date:_____

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