## Shape Retaining Receptacle

## Accessories for Non-Ambulatory and Night Use

## Full Line of Cleansing Accessories

**Please fax completed prescription to:**

Fax 1: 704-307-2625

or

Fax 2: 704-332-3425

**Or mail completed prescription to:**

Arcus Medical
4324 Barringer Dr, Suite 104
Charlotte, NC 28217

**Customer Support**

Toll Free: 877-272-8763

Phone: 704-332-3424

Email: sales@arcusmedical.com

arcusmedical

4324 Barringer Dr . Suite 104 . Charlotte . NC . 28217

www.arcusmed.com



# Innovation for Men

Medicare Coverage Available

**100% Latex Free**

Designed . Patented . Made in USA

**Discreet**

**No Contact Adhesives**

**Fast Flow Capable**

**Cotton Fabric Briefs**

## 1 Physicians Written Order and Prescription

**Instructions:** Please complete ALL blanks. If you fax this document, Medicare and/or Insurance requires that the providers maintain the signed original in the patient's medical record for post payment review and audit purposes.

The patient indicated in ths CMN has been diagnosed with (please check all applicable codes):

- ☐ 788.37 Incontinence, Continuous Leakage
- ☐ 788.32 Incontinence, Stress, Male
- ☐ 788.33 Incontinence, Mixed
- ☐ 788.31 Incontinence, Urge
- ☐ 788.34 Incontinence w/o Sensory Awareness
- ☐ 788.41 Frequency
- ☐ 788.63 Urgency of Urination
- ☐ 788.42 Polyuria
- ☐ 788.43 Nocturia
- ☐ 596.54 Neurogenic Bladder
- ☐ Other: _____

I have prescribed the Afex Incontinence Management System along with replacement parts as needed and described herein. It is my expert opinion that a collection system is medically necessary to facilitate management of this patient's urinary function. This prescription shall also serve as the Certificate of Medical Necessity. Dispense as written.

Estimated Length of Need (# months): _____ (99 = Lifetime)

Prognosis: ☐ Good ☐ Fair ☐ Poor

Physician is enrolled in Medicare PECOS System with Urological Supplies Authorization: ☐ Yes ☐ No

UPIN #: _____ NPI #: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

**Physician Signature** _____ **Date** _____

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Charlotte, NC 28217

Phone: 704-332-3424

**Medicare requires relevant Patient Medical Records in support of this Certificate of Medical Necessity as enforcement of Section 1833(e) of the Social Security Act. Supplier may request copies of relevant patient medical records to support this CMN.**

## 2 Narrative Description of Items

| | HCPCS Code | Description | Replacement | Price |
|---|---|---|---|---|
| ☐ | A5105 | Receptacle plus Collection Bag | 30 Days per Unit | $62.90 |
| ☐ | A5131 | 16oz Urinary Appliance Cleaner | 30 Days per Unit | $16.95 |
| ☐ | A4357 | Bedside Drainage Bag | 15 Days per Unit | $14.95 |

3 month supply provided unless otherwise noted. A5131 is recommended with A5105 for daily cleansing of the device. Briefs (HCPCS A4466) must be purchased separately. Patient is contacted by telephone prior to each shipment for verification of medical need.

## 3 Patient Information

Date of Birth: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Phone Number: _____

## 4 Assignment of Benefits (AOB)

I am interested in learning more about the Afex line of products and I authorize a representative of Arcus Medical to contact me. I authorize Arcus Medical to contact my physician as well as any authorized representatives or systems of Medicare, Medicaid, or other insurance for release of medical and other information to obtain products requested through this order. My signature authorizes Arcus Medical to submit and process claims on my behalf and that assignment of benefits for items obtained from Arcus Medical will be directly paid to Arcus Medical. I have received and acknowledge the Client Bill of Rights and Medicare Supplier Standards. This consent is subject to revocation at any time upon the submittal of a written statement.

_____ _____

**Patient Signature (Required)** **Date**

**Medicare Number:** ☐☐☐ ☐☐ ☐☐☐☐ ☐ **Required for Eligibility Verification.**

**Medicare is my Primary Insurance:** ☐ Yes ☐ No

**Supplemental Insurance Information (Optional)**

Provider: _____

Policy Holders Name: _____

Policy # _____ Group # _____

Phone: _____

**If Medicare is not your Primary Insurance or if you use a Medicare Advantage Plan, please provide copies of ALL your insurance and Medicare cards.**