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.

Patient Diagnosis (please check all applicable ICD-9 and equivalent ICD-10 codes):

- ☐ 788.30 Urinary Incontinence (R32)
- ☐ 788.31 Urge Incontinence (N39.41)
- ☐ 788.32 Stress Incontinence (N39.3)
- ☐ 788.33 Mixed Incontinence (N39.46)
- ☐ 788.34 Incontinence w/o Sensory Awareness (N39.42)
- ☐ 788.35 Post Void Dribbling (N39.43)
- ☐ 788.39 Other Urinary Incontinence (N39.498)
- ☐ 788.37 Incontinence, Continuous (N39.45)
- ☐ 788.41 Frequency (R35.0)
- ☐ 788.42 Polyuria (R35.8)
- ☐ 788.43 Nocturia (R35.1)
- ☐ 788.63 Urgency of Urination (R39.15)
- ☐ 596.54 Neurogenic Bladder (N31.9)

I have prescribed the Afex Incontinence Management System along with accessory 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: ☐ Yes ☐ No

UPIN #: _____ NPI #: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

_____ _____

Physician Signature **Date**

Please Fax Completed Prescription To:

Fax 1: 704-307-2625 or

Fax 2: 704-332-3425

Or Send By Mail To:

Arcus Medical
4324 Barringer Dr, Suite 104
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	Allowed Quantity
☒	A5105	Receptacle, Bag, Core Supporter	1 unit/month or 3 units/3 months
☒	A5131	16oz Urinary Appliance Cleaner	1 unit/month or 3 units/3 months
☒	A4357	Bedside Drainage Bag	2 unit/month or 6 units/3 months
☒	A4356	Transitional Penile Clamp	1 unit/3 months

3 month supply provided unless otherwise noted. Sports Active Briefs must be purchased separately. Patient is contacted by telephone prior to each shipment for verification of 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 using the Afex line of products and I authorize a representative of Arcus Medical or its Assign ("DME") to contact me. I authorize DME 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 DME to submit and process claims on my behalf and that assignment of benefits for items obtained from DME will be directly paid to DME. 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.