



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: <input type="checkbox"/> M <input type="checkbox"/> F
Date of birth:	SSN:	Phone:
Street address:		Email:
City, State, Zip:		
Primary Insurance:	Secondary Insurance:	
Phone number: Group:	Phone number: Group:	
Patient ID:		Patient ID:

PRESCRIBED RENEW INSERT PRODUCT

<input type="checkbox"/> Starter Pack Ref FG715 (3 Regular and 2 Large Inserts)	<input type="checkbox"/> Regular Ref FG730 (Pack of 30 Regular Sized Inserts)	<input type="checkbox"/> Large Ref FG731 (Pack of 30 Large Sized Inserts)
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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: <input type="checkbox"/> Indefinite <input type="checkbox"/> _____ Years <input type="checkbox"/> _____ Months Number of Refills: _____ Permanent Fecal Incontinence (90 days or greater): <input type="checkbox"/> Yes <input type="checkbox"/> No	ICD9 / ICD10 Diagnosis <input type="checkbox"/> 787.60 / R15.9 Full incontinence of feces <input type="checkbox"/> 787.61 / R15.0 Incomplete defecation <input type="checkbox"/> 787.62 / R15.1 Fecal smearing <input type="checkbox"/> 787.63 / R15.2 Fecal urgency <input type="checkbox"/> _____ Other _____
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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.