



# Doctor Order Form

## Ostomy Supplies

185 Oser Ave.  
Hauppauge, NY 11788  
Call: 1.800.854.5729  
Fax: 1.877.262.2183

**Instructions:** Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

[www.BetterLivingNow.com](http://www.BetterLivingNow.com)

<b>Referral</b>	Order Date:	Ordered By:	<b>Referral Source</b>		Phone#:	Referral Source #:	Referral Type #:	BLN Processor:
<b>Patient Info</b>	BLN Account Number:	Patient's Primary Insured ID#:	Patient's Secondary Insured ID#:		Sex:	Date of Birth:		
	<i>BLN Account #</i>	<i>Patient's ID# 1</i>	<i>Patient's ID# 2</i>		<i>M F</i>	<i>/DOB/</i>		
	Patient's Last Name:	Patient's First Name:	Middle Initial:	Relationship to Member:	Daytime Phone Number:			
<b>Member</b>	Member's Primary Insured ID#:	Member's Last Name:	Member's First Name:	Middle Initial:	Date of Birth:	Sex: (Circle)	Daytime Phone Number:	
	<i>Member's ID#</i>	<i>Last Name</i>	<i>First Name</i>	<i>/DOB/</i>	<i>M F</i>			
	Address 1:	Apt#:	City:	State:	Zip Code:	Nighttime Phone Number:		
<b>Primary Insurance</b>	Primary Insurance:	Policy / Group #:		<b>Secondary / Supplemental Insurance</b>	Secondary Insurance:	Policy / Group #:		
	Primary Insurance Address:	Insurance Type: <input type="radio"/> Medicare <input type="radio"/> Indemnity <input type="radio"/> HMO <input type="radio"/> PPO			ID Number for Secondary Policy:	Secondary Insurance Type: <input type="radio"/> Medicare <input type="radio"/> Indemnity <input type="radio"/> HMO <input type="radio"/> PPO		
		Primary Insurance Phone #:			Secondary Insurance Address:	Secondary Insurance Phone #:		
	City:	State:	Zip Code:		City:	State:	Zip Code:	
	BLN Payer #:	Authorization#:	Contact:		BLN Payer #:	Authorization#:	Contact:	
<b>Payment Info</b>	<b>Cash</b>		Charge to Credit Card:			Cardholder Signature:		
	<input type="radio"/> COD <input type="radio"/> Check or Money Order payable to <b>Better Living Now, Inc.</b>		<input type="radio"/> MasterCard <input type="radio"/> Visa <input type="radio"/> Discover <input type="radio"/> American Express			<i>Cardholder Signature</i>		
<b>Diagnosis</b>	Check Appropriate Diagnosis: [Colostomy] <input type="radio"/> V44.3 <input type="radio"/> V55.3 [Ileostomy] <input type="radio"/> V44.2 <input type="radio"/> V55.2							
	[Urostomy] <input type="radio"/> V44.6 <input type="radio"/> V55.6 <input type="radio"/> Other : _____ <input type="radio"/> Prognosis : _____ <b>Size of Stoma :</b> _____							
<b>Allergies</b>	Do you have any allergies to products applied to the skin? <input type="radio"/> Yes <input type="radio"/> No (If yes, please list) Allergies to Latex? <input type="radio"/> Yes <input type="radio"/> No							
<b>- Ostomy Supplies Order – (Please circle size &amp; type) * Medicare allows up to a 90-day supply of Ostomy Supplies</b>								
<b>Check</b>	<b>Please Circle Size and Type where necessary</b>					<b>Order Number</b>	<b>Quantity</b>	
<input checked="" type="checkbox"/>	Pouch (box) <input type="radio"/> One Piece <input type="radio"/> Two Piece (to use w/ flange) <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Flange w/ Skin Barrier to use with Two Piece Pouch (box) <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Skin Barrier 2oz (each) <i>Paste</i> <i>Powder</i> <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Skin Prep Wipes (box) <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Adhesive Remover Wipes (box) <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Skin Barrier Wafer Solid (box) <input type="radio"/> 4" x 4" <input type="radio"/> 6" x 6" <input type="radio"/> 8" x 8" <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Tape (roll) <input type="radio"/> Paper <input type="radio"/> cloth <input type="radio"/> waterproof <input type="radio"/> 1" <input type="radio"/> 2" <input type="radio"/> 3" <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Night Urinary Drainage Collector (each) <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Bedside Urinary Drainage Bag 2000cc <span style="float: right;">Please provide order number</span>							
<input type="checkbox"/>	Other: <span style="float: right;">Please provide order number</span>							
<b>Doctor's Information</b>	Dr.'s Stamp:		THIS PRESCRIPTION WILL BE FILLED GENERALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW				<b>Dispense:</b>	
	Dr.'s Name:		<input style="width: 100px; height: 30px;" type="text"/>				<input type="radio"/> 1 Month Supply	
	Dr.'s Address:		Dispense As Written				<input type="radio"/> 3 Month Supply	
	Dr.'s City:	State:	Zip Code:	Dr.'s Signature:		Date of Visit:		
	Dr.'s Phone#:	Dr.'s UPIN#:	Dr.'s License#:		Dr.'s DEA#:			

OS0301

\*\*\*Please see other side for additional instructions\*\*\*



# Doctor Order Form - Ostomy Supplies

## Instructions

185 Oser Ave.  
Hauppauge, NY 11788  
Phone: 1.800.854.5729  
Fax: 1.877.262.2183

[www.BetterLivingNow.com](http://www.BetterLivingNow.com)

- 1) **Patient**
  - a) Please complete the Member section of the order form on the reverse side indicating the insurance you have that provides coverage for your Ostomy Supplies.
- 2) **Doctor**
  - a) Please complete the patient information and doctor information sections.
  - b) Please indicate the products you want supplied to the patient, with directions for use and quantity required;
  - c) Please sign and date on the spaces provided.
- 3) **Some Medicare Coverage Rules that should be noted:**
  - a) Medicare reimbursement limits Ostomy Supplies to a **three (3) months supply** at one time.
  - b) If treatment regimen exceeds the quantity limitations noted below, then Medicare requires a Letter of Medical Necessity signed by the physician on his or her letterhead.
  - c) **If you fax this document**, Medicare/insurance requirements are that you maintain the signed original in the patient's medical record for post-payment review audit purposes.
- 4) **Medicare Guidelines for Ostomy Supplies**  
 Note: Monthly allowable amounts do not represent a benefit limit. The actual quantity needed by a particular customer may be more or less than the amount listed, depending on the individual customer's medical condition. Customers ordering over the allowable amount must have appropriate medical justification (i.e. a letter of medical necessity)

Effective 01/01/2003	Quantity Limitations	Effective 01/01/2003	Quantity Limitations
<b>Adhesives and Adhesive Removers</b>		<b>Other</b>	
<b>Adhesive (Cement), Liquid Or Equal, Any Type, Per Oz (A4364)</b>	4 oz per month	<b>Appliance Cleaner, Incontinence And Ostomy Appliances, Per 16 Oz. (A5131)</b>	16 oz per month
<b>Adhesive Remover Or Solvent (For Tape, Cement Or Other Adhesive), Per Ounce (A4455)</b>	8 oz per 3 months 16 oz per 6 months	<b>Bedside Drainage Bag, Day Or Night, With Or Without Anti-Reflux Device, With or Without Tube, Each (A4357)</b>	2 ea per month
<b>Adhesive Or Non-Adhesive; Disk Or Foam Pad (A5126)</b>	20 per month	<b>Bedside Drainage Bottle With Or Without Tubing, Rigid Or Expandable, Each (A5102)</b>	1 ea every 3 months 2 ea every 6 months
<b>Pouches</b>		<b>Belt, Ostomy (A4367)</b>	1 ea per month
<b>Ostomy Pouch, Closed (A5051, A5052, A5053, A5054)</b>	Up to 60 per month	<b>Continent Device; Catheter For Continent Stoma (A5082)</b>	1 per month
<b>Ostomy Pouch, Drainable – 2 piece (A5063)</b>	Up to 20 per month	<b>Continent Device; Plug For Continent Stoma (A5081)</b>	31 per month
<b>Ostomy Pouch, Drainable – 1 piece (A5062, K0567, K0568)</b>	Up to 20 per month	<b>Gauze, Non-Impregnated, Non-Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing (A6216)</b>	60 per month
<b>Ostomy Pouch, Drainable, For Use On Faceplate, Plastic, Each (A4377)</b>	10 per month	<b>Irrigation Supply; Sleeve, Each (A4397)</b>	4 per month
<b>Ostomy Pouch, Urinary, For Use On Faceplate, Plastic, Each (A4381)</b>	10 per month	<b>Lubricant, Per Ounce (A4402)</b>	4 oz per month
<b>Ostomy Pouch, Urinary – 2 piece (A5073)</b>	20 per month	<b>Ostomy Accessory; Convex Insert (A5093)</b>	10 per month
<b>Ostomy Pouch, Urinary – 1 piece (A5071, A5072)</b>	20 per month	<b>Ostomy Faceplate, Each (A4361)</b>	3 per 6 months
<b>Wafers/Flanges</b>		<b>Ostomy Irrigation Supply; Bag, Each (A4398)</b>	2 per 6 months
<b>Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion) (K0570, K0571, A4414, A4415)</b>	20 per month	<b>Ostomy Ring, Each (A4404)</b>	10 per month
<b>Skin Barrier; Solid, 4"x4", 6"x6", or 8"x8" (A4362, A5121, A5122)</b>	20 per month	<b>Stoma Cap (A5055)</b>	31 per month
<b>Skin Barriers</b>		<b>Tape, per 18 Square Inches (A4450, A4452)</b>	Varies by region. Approx. 2 rolls of 1" tape per month
<b>Ostomy Skin Barrier, Liquid (Spray, Brush, Etc), Per Oz (A4369)</b>	2 oz per month		
<b>Ostomy Skin Barrier, Paste, Per Ounce (K0561, K0562, A4405, A4406)</b>	4 oz per month		
<b>Ostomy Skin Barrier, Powder, Per Oz (A4371)</b>	5 oz per 3 months 10 oz per 6 months	<b>*Please note that Medicare will pay for a 3-month supply of Ostomy products at one time.</b>	
<b>Skin Barrier; Wipes, Box per 50 (A5119)</b>	150 per 6 months		