CWS MEDS™

Urological Patient Referral Form

Phone: 1-866-964-6337

STEP 1 Complete this referral form

STEP 2 Attach patient's demographic sheet and any supporting medical record documentation

STEP 3 Fax form to (toll free) 1-866-994-6337

Patient Name ______________________ **D.O.B.** ___/___/___ ☐ Male ☐ Female **Phone** ______________

DIAGNOSIS (check diagnosis)

Start Date ___/___/___

1st Diagnosis

- ☐ 788.30 Urinary Incontinence
- ☐ 788.20 Urinary Retention

2nd Diagnosis

- ☐ 600.01 BPH
- ☐ 340 Multiple Sclerosis
- ☐ 596.54 Neurogenic Bladder
- ☐ 185 Prostate Cancer
- ☐ 188.9 Bladder Cancer
- ☐ 344.00 Quadriplegia
- ☐ 344.1 Paraplegia

Spina Bifida (741)

- ☐ 741.00 Unspecified region with Hydrocephalus
- ☐ 741.01 Cervical region with Hydrocephalus
- ☐ 741.02 Dorsal (thoratic) region w/Hydrocephalus
- ☐ 741.03 Lumbar region with Hydrocephalus
- ☐ 741.90 Without mention of Hydrocephalus

- ☐ 756.17 Spina Bifida Occulta
- ☐ Other ______________________

Duration of Need = lifetime - unless otherwise noted ______________________

CATHETERS

☐ **Intermittent Urinary Catheter**

- ☐ Kit with Insertion Supplies ☐ Lubricant Packets ☐ Hydrophilic

☐ **Coudé Intermittent Urinary Catheter**

- ☐ Kit with Insertion Supplies ☐ Lubricant Packets

Mark Appropriate Justification

- ☐ BPH w/Obstruction ☐ Strictures ☐ False Passages ☐ Scar Tissue

☐ **Closed System Catheter**

☐ **Male External Catheter**

☐ **Indwelling Foley Catheter** Indicate Type ______________________

PRODUCT DESCRIPTION

Brand (circle one)

French Size ______________________

Quantity ______________________

Freq Change ______________________ PER MONTH

Length ______________________ PER DAY

Manufacturer ______________________ CATHETER

ADDITIONAL SUPPLIES

☐ Leg Bag ________ QUANTITY ☐ Bedside Bag ________ QUANTITY ☐ Other ________ QUANTITY

PATIENT AUTHORIZATION

I request that payment of my insurance benefits (Medicare, Medicare Supplemental or other) be made to Clinical Wound Solutions, LLC for any supplies or services furnished to me by Clinical Wound Solutions, LLC. I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize the release of my medical information/records to my insurer(s) as well as medical professionals. I authorize Clinical Wound Solutions, LLC to contact me by telephone, email or mail regarding my medical supplies.

Patient's Signature ______________________ **Date** ___/___/___

Use This Area For Comments

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REFERRING PHYSICIAN INFORMATION

Office ______________________

Address ______________________

Phone ______________________

Fax ______________________

Physician's NPI# ______________________

Physician's Signature ______________________ **Date** ___/___/___

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of this patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Supplies may be provided by Clinical Wound Solutions, LLC. For additional information call us at 1-866-964-6337. This is a confidential message. It is intended solely for the person to whom it is addressed. It must be kept in strict confidence. If you receive this message in error, please forward it by toll-free fax to 1-866-994-6337 and destroy the copy you received. Thank You.

Common Diagnosis Codes

Phone: 1-866-964-6337
Fax: 1-866-994-6337

788.30 Urge Incontinence, Unspecified
- **788.31** Urge Incontinence
- **788.32** Stress Incontinence, (Male)
- **788.33** Mixed Incontinence (Male, Female)
- **788.37** Continuous Leakage
- **788.1** Dysuria. Difficulty Or Pain In Urination

788.20 Urinary Retention, Unspecified
788.21 Incomplete Bladder Emptying
787.6 Fecal Incontinence

741 Spina Bifida
- **741.00** Unspecified Region With Hydrocephalus
- **741.01** Cervical Region With Hydrocephalus
- **741.02** Dorsal (Thoratic) Region With Hydrocephalus
- **741.03** Lumbar Region With Hydrocephalus
- **741.90** Without Mention Of Hydrocephalus

756.17 Spina Bifida Occulta

344 Other Paralytic Symptoms
- **344.00** Quadriplegia And Quadraparesis
- **344.01** Quadriplegia, C1-C4 Complete
- **344.02** Quadriplegia, C1-C4 Incomplete
- **344.03** Quadriplegia, C1-C7 Complete
- **344.04** Quadriplegia, C1-C7 Incomplete

344.1 Paraplegia
344.61 Cauda Equina Syndrome With Nurogenic Bowel
600.11 Nodular Prostate With Urinary Obstruction
600.21 Benign Localized Hyperplasia Of Prostate With Urinary Obstruction

564.81 Neurogenic Bowel
585.6 End Stage Renal Disease (Esrd)
594.1 Other Calculus In Bladder
596.0 Bladder Neck Obstruction
596.2 Vesical Fistula Not Elsewhere Classified
596.4 Atony Of Bladder
596.51 Hypertonicity Of Bladder
596.52 Low Bladder Compliance
596.53 Paralysis Of Bladder
596.55 Detrusor Sphincter Dysynergia

598 Urethral Stricture
- **598.0** Urethral Stricture Due To Unpecified Infection
- **598.1** Traumatic Urethral Stricture
- **598.2** Postoperative Urethral Stricture
- **598.8** Other Specific Causes Of Urethral Stricture
- **598.9** Urethral Stricture Unspecified

599 Other Disorders Of Urethra And Urinary Tract
- **599.1** Urethral Fistula
- **599.2** Urethral Diverticulum
- **599.3** Urethral Caruncle
- **599.4** Urethral False Passage
- **599.5** Prolapsed Urethral Mucosa

599.60 Urinary Obstruction Unspecified
599.69 Urinary Obstruction Not Elsewhere Classified
599.7 Hematuria
599.70 Hematuria, Unspecified
599.71 Gross Hematuria
599.72 Microscopic Hematuria

Urological Medicare Utilization Guidelines

PRODUCT	PER MONTH	SPECIAL COMMENTS
Indwelling Catheters		
Latex Foley	1	
Coude/Silastic/All Silicone Foley	1	With proper documentation showing medical necessity—provide an explanation of why the patient cannot use a straight foley catheter with coating.
Intermittent Catheters		
Straight/Coude	up to 200	Doctor order must list quantity used per month.
Sterile Lubricant Packet	200	
Sterile Catheter Kit/Closed System	up to 200	**Patient must meet 1 of 5 coverage criteria** 1. The patient has had distinct, recurrent urinary tract infections while on a program of sterile intermittent catheterization, twice within the 12 months prior to the initiation of sterile intermittent catheter kits. 2. The patient resides in a nursing facility. 3. The patient is immunosuppressed. 4. The patient has radiologically documented visico-urethral reflux while on a program of intermittent catheterization. 5. The patient is a spinal cord injured female with neurogenic bladder who is pregnant.
External Catheters		
Male	35	
Specialty Male External Catheter	30	With proper documentation showing necessity.
Trays/Bags		
Insertion Tray	1	
Irrigation Kit	1	
Bedside Drain Bag	2	
Leg Bag (Vinyl/Latex)	2	
Accessories		
Irrigation Syringe		
Extension Tubing	1	
Cath Strip	3/wk	For indwelling catheters only.
Leg Strap	1	For indwelling catheters only.
Tape	5 yds/month	For indwelling catheters only.
Cath Tube Anchor Device	2	For suprapubic tube/nephrostomy tube