Lifecare Technology, Inc
O- 985.649.3019 F - 985.643.0422 E - insurance@lifecaremedical.com

DME REFERRAL FORM

****Has Patient been notified of and chosen Lifecare Technology for this order?****

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS WITH THE INITIAL ORDER

First Name:		Last Name:	
Street Address(No P.O. Boxes):			Phone:
City:		State:	Zip:
Sex: M F	Ht:	Wt:	DOB:

REFERRAL INFORMATION

Name of Facility:	
Referral Contact:	Phone #:

Is Patient being seen by Home Health? ☐ YES ☐ NO

INSURANCE INFORMATION:

Primary: ☐ Medicare ☐ Medicaid ☐ Other:

Name:		Address:	
City:	State:	Zip:	Phone:
Policy #:		Group #:	

DIAGNOSIS / ICD10 CODE:

☐ Colostomy **Z93.3** ☐ Ileostomy **Z93.2** ☐ Urostomy **Z93.6** ☐ Encounter for Ileostomy **Z43.2** ☐ Encounter for Urostomy **Z43.6**

MANUFACTURER: ☐ HOLLISTER ☐ COLOPLAST ☐ CONVATEC ☐ SECURI-T

	Item #	Quantity	Frequency of Use
☐ One Piece Pouch ☐ Closed ☐ Drainable ☐ Urostomy			
☐ Two Piece Pouch ☐ Closed ☐ Drainable ☐ Urostomy			
☐ Flange with Skin Barrier (required for Two Piece Pouch)			
☐ Tape ☐ 2" Cloth ☐ 2" Medipore			
☐ Skin Prep Wipes (Box) ☐ Regular ☐ Sting Free			
☐ Adhesive Remover Wipes			
☐ Paste (2oz)			
☐ Strip Paste			
☐ Barrier Strips			
☐ Deodorant (8oz bottle)			
☐ Adhesive Ring size_____			
☐ Barrier Ring size_____			
☐ Wafer ☐ 2" ☐ 4"			
☐ Urinary Drainage Bag ☐ 2000ml ☐ 900ml			
☐ Cleaner/Decrystalizer 16 oz/Cleaner			
☐ Powder (1oz)			
☐ Ostomy Belt size _____			
☐ Other			
☐ Other			

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. This document may serve as a verbal order and is also written in the patient's record. The forgoing information is true, accurate and complete. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**

Ordering Physician or Licensed Prescriber (Please Print) _____

Address _____ Phone _____ Fax _____

Signature _____Date _____ NPI # _____

Length of Need _____ **Months** **Start Date** _____/_____/_____ **End Date** _____/_____/_____