



Medically Modern DME  
Phone / Fax: (347) 817-1037  
Email: care@medicallymodern.com  
161 E Main St, Mount Kisco, NY 10549

# Prescription

Incontinence Supplies – Written Order

## Patient Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medicaid ID (CIN): \_\_\_\_\_

## Prescription Information

Length of Need (# of months): \_\_\_\_\_

Refills: \_\_\_\_\_

Check only the products and sizes that apply.

| Product                                   | Adult Size (inches)                                                                                                                                                                                                     | Youth Size                                                                                                                                                         | Quantity per month    |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| <input type="checkbox"/> Diapers          | <input type="checkbox"/> Small (20-34")<br><input type="checkbox"/> Medium (34-44")<br><input type="checkbox"/> Large (44-58")<br><input type="checkbox"/> X-Large (58-62")<br><input type="checkbox"/> XX-Large (>62") | <input type="checkbox"/> 4 (22-27 lbs)<br><input type="checkbox"/> 5 (28-34 lbs)<br><input type="checkbox"/> 6 (35-40 lbs)<br><input type="checkbox"/> 7 (41+ lbs) | Diapers: _____ each   |
| <input type="checkbox"/> Pullups          | <input type="checkbox"/> Small (20-34")<br><input type="checkbox"/> Medium (34-44")<br><input type="checkbox"/> Large (44-58")<br><input type="checkbox"/> X-Large (58-62")<br><input type="checkbox"/> XX-Large (>62") | <input type="checkbox"/> Youth S/M (38-65 lbs)<br><input type="checkbox"/> Youth L/XL (65-140 lbs)                                                                 | Pullups: _____ each   |
| <input type="checkbox"/> Liners           | <input type="checkbox"/> Panty Liners 6 x 17 <input type="checkbox"/> Prevail Liners                                                                                                                                    |                                                                                                                                                                    | Liners: _____ each    |
| <input type="checkbox"/> Gloves           | <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large                                                                                          |                                                                                                                                                                    | Gloves: _____ box(es) |
| <input type="checkbox"/> Chux / Underpads |                                                                                                                                                                                                                         |                                                                                                                                                                    | Chux: _____ each      |

## Ordering Practitioner

Order Date: \_\_\_\_\_

Patient Diagnosis (practitioner to check all that apply and enter the complete ICD-10-CM code):

|                                                                                                                                                               |                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> N39.41 Urge incontinence<br><input type="checkbox"/> N39.3 Stress incontinence<br><input type="checkbox"/> N39.46 Mixed incontinence | <input type="checkbox"/> R39.81 Functional urinary incontinence<br><input type="checkbox"/> R15.9 Full incontinence of feces |
| <input type="checkbox"/> Other: _____ ICD-10-CM code: _____                                                                                                   |                                                                                                                              |

NY Medicaid requires a valid, complete ICD-10-CM diagnosis code on the order that matches the claim and is supported by the medical record. The codes listed are from the NY Medicaid (eMedNY) acceptable-diagnosis list for incontinence products (page dated April 2023); current acceptance is not guaranteed. Use Other for any code not listed.

The diagnosis and need are documented in my medical record.

Practitioner Name: \_\_\_\_\_

Practitioner NPI #: \_\_\_\_\_

Practitioner Address: \_\_\_\_\_

Practitioner Phone: \_\_\_\_\_

Practitioner Fax: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please fax this signed order and your most recent office note documenting the diagnosis and the need for the quantities ordered to (347) 817-1037.

Questions? Call (347) 817-1037.