Medline Incontinence Supply Order Form

Ohana Health Plan
Fax 866- 381-9546
Phone 833-660-0905
Email Ohana@Medline.com

Member Information

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Tel: _____ **DOB:** _____ ☐ **Male** ☐ **Female**

E-Mail: _____

ICD-10 Code/Diagnosis: _____

Height: _____ **Weight:** _____

Briefs (Adult Diapers)

HCPCS	Item	Size (Waist Size)	Quantity Per Month (Ea)
T4521	Small Brief	Small 20"-33"	
T4522	Medium Brief	Medium 32"-42"	
T4522	Regular Brief	Regular 40"-50"	
T4523	Large Brief	Large 48"–58"	
T4524	Extra Large Brief	X-Large 57"-66"	
T4543	XXL Brief	XX-Large 60"-69"	

Pull-Ups

HCPCS	Item	Size (Waist Size)	Quantity Per Month (Ea)
T4525	Protective Underwear	Small 20"-28"	
T4526	Protective Underwear	Medium 28"-40"	
T4527	Protective Underwear	Large 40"-56"	
T4528	Protective Underwear	X-Large 56"-68"	
T4544	Protective Underwear	XX-Large 68"-80"	

Other

HCPCS	Item	Size	Quantity Per Month (Ea)

Insurance Information

Primary Insurance: _____

Primary Insurance Policy Number ID _____

Secondary Insurance: _____

Secondary Insurance Policy Number ID _____

Policy Holder Name: _____

Policy Holder Relation to Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Parent**

Physician's Name: _____

Physician's Phone Number: _____

Physician's Fax Number: _____

Name of Ordering Contact: _____

Ordering Contact Phone: _____

Ordering Contact E-mail: _____

Start Date: _____ **Duration of need:** _____

Patient Information (Check Only If Applicable):
☐ Tube-Fed ☐ Diabetic ☐ Non-Ambulatory ☐ On A Diuretic

Underpads

HCPCS	Item	Size	Quantity Per Month (Ea)
T4542	Small	17" x 24"	
T4541	Large	23" x 36"	

Liners

HCPCS	Item	Size	Quantity Per Month (Ea)
T4535	Bladder Pads	2 ¾" x 9 ¾"	
T4535	Bladder Pads	3" x 10 ½"	
T4535	Bladder Pads	3 ½" x 13"	
T4535	Bladder Pads	5 ½" x 10 ½"	
T4535	Bladder Pads	6 ½" x 13 ½"	
T4535	Bladder Pads	8" x 17"	

OPTIONAL - IF PATIENT CONSENT IS REQUIRED

Patient Authorization of Release of Information and Assignment of Benefits: I certify that the information given by me in applying for payment under Medicare (title XVII of the Social Security Act) and/or any other Medical Insurance is correct. I authorize the release to Medline Industries, Inc., any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Medline Industries, Inc. on assigned claims. I authorize Medline Industries, Inc., to submit claims to Medicare and/or any other Medical Insurance carrier. I agree to assume financial responsibility for any balances for supplies furnished to me by Medline Industries, Inc., not authorized by my insurance policy. This includes but is not limited to deductibles, co-insurance and non-covered items. I authorize that photo copies shall be valid as originals..

Patient Signature / Legal Rep: _____ **Date:** _____

Relationship to Patient: _____

Reason Patient unable to sign: _____

Ordering Provider

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed copy of this order in my medical records.

(Please Print)

Ordering Physician or Licensed Prescriber: _____

Facility Name: _____

Tel: _____ **Fax:** _____

Signature*: _____

Date*: _____ **NPI#:** _____

*Signature and Date Stamps Are Not Acceptable.