BARD | LIBERATOR MEDICAL

Prescription for Medical Supplies

P.O. Box 446
Stuart, FL 34995-0446
Ph: 888-329-5679
Fax: 888-324-0447

PATIENT INFO

Patient Account #
Name:
Address:
:
:
Phone:
DOB:
Gender:

Order Date:
Order Time:
LMS Rep:
LMS Rep Phone: 888-329-5679
LMS Rep Ext.:
Physician Rep:

INSTRUCTIONS: Please fill in all sections and mail or fax back to Liberator Medical Supply, Inc.
If you have any changes, please cross out, write in correction, sign and date it.

Section A — DIAGNOSIS

Primary Diagnosis

☐ **R33.9 Retention of Urine, Unspecified** ☐ **R32 Urinary Incontinence, Unspecified** ☐ **Other:**

Secondary Diagnosis

☐ **N13.9 Obstructive and Reflux Uropathy, Unspecified**
☐ **N31.9 Neuromuscular Dysfunction of Bladder**
☐ **N32.0 Bladder Neck Obstruction**
☐ **N35.9 Urethral Stricture, Unspecified**
☐ **N39.45 Continuous Leakage**
☐ **N40.1 Enlarged Prostate with Lower Urinary Tract Symptoms**
☐ **Spinal Cord Injury NOS (Please check one below)**
☐ **S14.109A** ☐ **S24.109A** ☐ **S34.109A** ☐ **S14.139A**
☐ **Other:**

Section B — PATIENT SUPPLIES

	HCPCS Code	Description	Medicare/Insurance Usual Max. Quantity 30 Day Supply	Per Day Usage	Quantity You Are Approving	Changes You Are Making	Your Initials & Date Here If You Make Changes
1							
2							
3							
4							
5							
6							
7							
8							

Section C — DURATION OF NEED: 99 months (lifetime) unless you specify otherwise here ☐

By my signature below, I am stating that the patient is/was being treated by me. All the information contained on the Prescription for Medical Supplies accurately reflects the patient's condition and the treatment regimen I prescribed. My medical records for this patient substantiate the prescribed use of products. I will maintain a copy of this signed original Prescription for Medical Supplies in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Section D — PHYSICIAN INFO

Name:
Address:
:
:
Phone:
Fax:
NPI#:

Section E — PHYSICIAN SIGNATURE

Signature

Printed Name Date

Please send a copy of your chart notes along with this request.

Please initial and date all changes on forms. Please Sign, Date & Fax Back to 888-324-0447.

BARD | LIBERATOR MEDICAL

Authorization for Ostomy Supplies

P.O. Box 446
Stuart, FL 34995-0446
Ph: 888-329-5679
Fax: 888-273-5530

PATIENT INFO

Patient Account #:
Name:
Address:
:
:
Phone:
DOB:
Gender:

Order Date:
Order Time:
Start Date:

LMS Rep:
LMS Rep Phone:
Physician Rep:

INSTRUCTIONS: Please fill in all sections and mail or fax back to Liberator Medical Supply, Inc.
If you have any changes, please cross out, write in correction, sign and date it.

Section A — DIAGNOSIS

___ Colostomy Z93.3 / Z43.3 ___ Ileostomy Z93.2 / Z43.2 ___ Urostomy Z93.6 / Z43.6

___ Other _____

Section B — PATIENT SUPPLIES

	Description	Medicare/Insurance Usual Maximum 30 Day Supply	Per Day Usage	Quantity You Are Approving	Changes You Are Making	Your Initials & Date Here If You Make Changes
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Section C — DURATION OF NEED:

99 months (lifetime) unless you specify otherwise here: ____

By my signature below, I am stating that the patient is/was being treated by me. All the information contained on the Authorization for Ostomy Supplies accurately reflects the patient's condition and the treatment regimen I prescribed. My medical records for this patient substantiate the prescribed use of products. I will maintain a copy of this signed original Authorization for Ostomy Supplies in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Section D — PHYSICIAN INFO

Name:
Address:
:
:
Phone:
Fax:
NPI#:

Section E — PHYSICIAN SIGNATURE

Signature

Printed Name Date

Please send a copy of your chart notes along with this request.

Please initial and date all changes on forms.

BARD | LIBERATOR MEDICAL

Physician Work Order Diabetic Testing Supplies

P.O. Box 446
Stuart, FL 34995-0446
Phone: 888-329-5679
Fax: 888-273-5530

PATIENT INFO

Name:
Address:
:
:
Phone:

DOB:

Order Date: November 20, 2017
Order Time:
LMS Rep:
LMS Rep's Phone: 888-329-5679
LMS Rep's Ext:

Section A — DIAGNOSES

1. ICD 10 Diagnosis Code: ☐ E11.9 ☐ E10.9 ☐ E10.65 ☐ E11.65 ☐ Other_____

2. Is the patient managing their form of diabetes with insulin injections? ☐ Yes ☐ No

3. Prescribed frequent testing is due to which reason: _____

Note: The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement.

Please include a copy of chart notes to support testing frequency and medical reason with this order.
Please note that most insurance plans consider any patient testing over 1XD non-insulin and 3XD insulin injecting to be over-utilizing and will require chart notes within the last 6 months to support.

Section B — PATIENT SUPPLIES

	Description	Per day usage	Quantity You Are Approving	Changes You Are Making	Your Initials & Date Here If You Make Changes
1					
2					
3					
4					
5					
6					
7					

Section C

DURATION OF NEED: 99 months (lifetime) unless you specify otherwise here: _____

By my signature below, I am stating that the patient has diabetes and is/was being treated by me. All the information contained on this Physician Work Order accurately reflects the patient's diabetic condition and the treatment regimen I prescribed. I have seen this patient within the last (6) months to evaluate his/her diabetes control testing frequency and this document confirms my order. I have reviewed this patient's testing results for controlling diabetes and my medical records for this patient substantiate the prescribed use of products. The patient/caregiver is able to follow my instructions for controlling diabetes and is able to use the ordered items. I will maintain a copy of this signed original Physician Work Order in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Section D — PHYSICIAN INFO

Name:
Address:
:
:
Phone:
Fax:
NPI#:

Section E — PHYSICIAN SIGNATURE

_____
Signature Date

_____
Printed Name

Please send a copy of your chart notes along with this request. Initial and date all changes on form.

Sign, date and fax back to 888-273-5530.