PureWick™ Urine Collection System Authorization Form

Form must be **manually signed** then faxed to (818)775-2941.

RA FISCHER CO.

Ph: (800)525-3467 | Fax: (818)775-2941

Patient Information

Please Attach History and Chart Notes *Additional documentation may be requested to document medical necessity.*

Patient Name	Gender ◯Female ◯Male	Date of Birth Month / Day / Year

Street Address	City	State	ZIP

Phone Number	Email

Primary Insurance	Member ID #
Secondary Insurance	Member ID #

Supply Information

PUREWICK™ SYSTEM *OR EQUIVALENT*

☐ **PureWick™ Urine Collection System** (E2001)

◯ Lifetime Use - OR - ◯ For Short Term Use: _____ month(s)

☐ **PureWick™ Disposable External Catheters** (A6590)

◯ **30** per month *(Overnight use)* - OR - ◯ **60** per month *(24 hour use)*

REPLACEMENT COMPONENTS *OR EQUIVALENT*

☐ **PureWick™ 2000cc Collection Canister** (A7001)

☐ **PureWick™ Replacement Collector Tubing** (A7002)

ICD CODES - DIAGNOSIS CODES

ICD-10-CM Code(s): ☐ R33.9 ☐ R32 ☐ N39.46 ☐ N39.42 ☐ N39.498 ☐ Other: _____

Physician Information

Physician Name	NPI	Tax ID

Office Name	Street Address	City	State	ZIP

Phone Number	Fax

LICENSED HEALTHCARE PROVIDER'S ACKNOWLEDGMENT

My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge.
I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that they will be contacted by RA Fischer regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

_____ Provider Signature

_____ / _____ / 2025 Date

PureWick™ Urine Collection System
Statement of Medical Necessity

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PATIENT INFORMATION:

Patient Name: _____

Date of Birth: ____ ____ _____
Month Day Year

Medicare Number: _____

DIAGNOSIS AND DURATION:

ICD-10-CM Code: _____

Duration: Lifetime, with reassessment annually or as needed based on patient's condition.

Date of Onset: ____ ____ _____
Month Day Year

PRESCRIBING PHYSICIAN INFORMATION

Physician Name		NPI		
Office Name	Street Address	City	State	ZIP
Phone Number	Fax			

MEDICAL STATEMENT OF NECESSITY:

_____ has a diagnosis of _____ . These conditions
(Patient's Name) (ICD-10)

significantly impair the ability to urinate effectively, leading to recurrent urinary tract infections (UTIs) and other complications.

Due to this condition, _____ requires the use of a urological device to manage their
(Patient's Name)

bladder function and prevent further complications.

PRESCRIBED EQUIPMENT:

(HCPCS E2001)Urological Device, Suction Pump:

- **Description:** A urological device, such as PureWick™ Urine Collection System , which is essential for the effective management of the patient's bladder function.
- **Medical Necessity:** The urological device is necessary to ensure the patient can empty their bladder effectively, reducing the risk of UTIs and improving overall quality of life. Without this device, the patient would likely face recurrent infections and increased medical complications.

(HCPCS A6590)Disposable Supplies: External Urinary Catheters, used with suction pump per month:

- **Description:** Disposable supplies, including but not limited to PureWick™ External Catheters, which are required in conjunction with the urological device.
- **Medical Necessity:** These disposable supplies are essential to maintain the hygiene and functionality of the urological device. Daily use is required to prevent infections and ensure proper device operation, thus safeguarding the patient's health.

SUMMARY OF CLINICAL EVALUATION:

[Include a summary of the patient's clinical evaluation, findings, and any relevant test results or imaging studies that support the need for the prescribed equipment]

PHYSICIAN'S CERTIFICATION

I certify that the prescribed urological device and disposable supplies are medically necessary for the treatment of the above-named patient's medical condition. I have reviewed the patient's medical history and conducted a thorough evaluation. The prescribed equipment is essential to the patient's treatment plan and cannot be met by any other means.

_____ ____ ____ 2025

Provider Signature Date

Authorization to Assign Benefits to the Provider and Release of Medical Information

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RA FISCHER CO.

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PATIENT ACKNOWLEDGMENT

I request that payment of authorized benefits be made on my behalf to AR Hinkel Co, Inc./RA Fischer Co. and affiliates for products or services that they may have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information for this or any related health care claim in writing or verbally.

I also authorize my insurance company(ies) to furnish to an agent of AR Hinkel Co, Inc./RA Fischer Co. and affiliates any and all information pertaining to my insurance benefits and status of claims submitted by AR Hinkel Co, Inc./RA Fischer Co. and affiliates for services rendered. I further authorize AR Hinkel Co, Inc./RA Fischer Co. and affiliates to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

I understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary.

If someone other than the patient is signing this authorization, please state the relationship with patient and the reason patient is unable to sign.

By signing below, I acknowledge that I have read and understand the information provided in this form. I consent to the use and disclosure of my protected health information as described, and I authorize Medicare and other payers to make direct payments to RA Fischer Co. for the services and supplies provided.

_____ Patient Signature

_____ 2025 Date

AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____ 2025

Diagnosis Code Reference Sheet

RA FISCHER CO.
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ICD-9	ICD-10	Diagnosis Description
340	G35	Multiple sclerosis
344.0	G82.5	Quadriplegia
344.1	G82.2	Paraplegia
344.6	G83.4	Cauda equina syndrome
344.61	G83.4	Cauda equina syndrome with neurogenic bladder
564.81	K59.2	Neurogenic bowel
595.1	N30.1	Chronic interstitial cystitis
596.0	N32.0	Bladder neck obstruction
596.4	N31.2	Atony of bladder
596.54	N31.9	Neurogenic bladder
598	N35	Urethral stricture
599.0	N39.0	Urinary tract infection
599.60	N13.9	Urinary obstruction, unspecified
600.0	N40	Hypertrophy (benign) of prostate
741	Q05	Spina bifida
741.0	Q05.4	Spina bifida with hydrocephalus
741.90	Q05.8	Spina bifida without hydrocephalus
753.5	Q64.1	Exstrophy of urinary bladder
753.6	Q64.3	Atresia and stenosis of urethra and bladder neck
788.1	R30.0	Dysuria
788.20	R33.9	Retention of urine, unspecified
788.21	R39.14	Incomplete bladder emptying
788.29	R33.8	Other specified retention of urine
788.30	R32	Urinary incontinence, unspecified
788.31	N39.41	Urge incontinence
788.33	N39.46	Mixed incontinence (urge & stress), female & male

ICD-9	ICD-10	Diagnosis Description
788.34	N39.42	Incontinence without sensory awareness
788.35	N39.43	Post-void dribbling
788.36	N39.44	Nocturnal enuresis
788.37	N39.45	Continuous leakage
788.38	N39.490	Overflow incontinence
788.39	N39.498	Other urinary incontinence
788.41	R35.0	Urinary frequency
788.43	R35.1	Nocturia
788.62	R39.12	Slowing of urinary stream
788.63	R39.15	Urgency of urination
625.6	N39.3	Stress incontinence, female
788.32		Stress incontinence, male
V44.2	Z93.2	Ileostomy status
V44.3	Z93.3	Colostomy status
V44.52	Z93.52	Appendicovesicostomy (Mitrofanoff)
V44.6	Z93.6	Other artificial opening of urinary tract status
V55.2	Z43.2	Attention to ileostomy
V55.3	Z43.3	Attention to colostomy
V55.6	Z43.6	Attention to other artificial opening of urinary tract
591	N13.30	Hydronephrosis
596.51	N32.81	Hypertonicity of bladder
600.01	N40.1	Hypertrophy (benign) of prostate with urinary obstruction
600.21	N40.1	Benign localized hyperplasia of prostate with urinary obstruction
788.69	R39.19	Other abnormality of urination, other
V43.5	Z96.0	Bladder replaced by other means

DOCUMENTATION REQUIREMENTS FOR MEDICARE PATIENTS

Additional documentation may be requested to document medical necessity.

Medicare requires that certain documentation be documented in the patient's chart/record in order for Medicare to reimburse for catheters. Medicare also highly recommends these documents be collected and maintained by the provider of supplies.

History of urological condition to include:

- **Permanency**: Medicare defines permanency as a condition that is expected to last greater than 90 days
- **Diagnosis**: Urological diagnosis
- **Frequency**: Frequency the patient is instructed to catheterize
- **History**: Duration of patient's condition

Reference: the requirements listed above can be referenced by referring to LCD for Urological Supplies (L11566). The above information is provided for reference only and is not intended as advice or instruction on how to complete a patient's detailed written order.