

# 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

|                     |  |                                                                   |  |                      |     |
|---------------------|--|-------------------------------------------------------------------|--|----------------------|-----|
| Patient Name        |  | Gender<br><input type="radio"/> Female <input type="radio"/> Male |  | Date of Birth<br>/ / |     |
| 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 ☐ For Short Term Use: \_\_\_\_\_ month(s)

#### ☒ PureWick™ Disposable External Catheters (A6590)

☒ 30 per month (Overnight use) ☐ 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    |  |
| <b>LICENSED HEALTHCARE PROVIDER'S ACKNOWLEDGMENT</b>                                                                                                                                                                                                                                                                                                                                                                                 |       |                |              |        |  |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                | Date         |        |  |



**PLEASE ATTACH HISTORY & CHART NOTES**



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# PureWick™ Urine Collection System Statement of Medical Necessity

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## Patient Information

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

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

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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Physician Information

|                |       |     |                |        |     |
|----------------|-------|-----|----------------|--------|-----|
| Physician Name |       | NPI |                | Tax ID |     |
| Office Name    |       |     | Street Address |        |     |
| City           | State | ZIP | Phone Number   |        | Fax |

## Medical Statement of Necessity:

\_\_\_\_\_ has a diagnosis of \_\_\_\_\_. These conditions significantly impair the ability to urinate effectively, leading to recurrent urinary tract infections (UTIs) and other complications. Due to this condition, this patient requires the use of a urological device to manage their 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.

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

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

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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

\_\_\_\_\_  
Date

### AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

## Additional Contact Information & Permission to Share Information *(Optional)*

You may list a caregiver, guardian, spouse, or another individual we may speak with regarding your order, insurance coverage, coordination of care, or other protected health information (PHI) related to the services we provide.

**By completing this section, I authorize RA Fischer Co. to disclose my protected health information (PHI) to the individual(s) listed below.**

### Contact 1

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email (Optional): \_\_\_\_\_

### Contact 2

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email (Optional): \_\_\_\_\_



**PLEASE ATTACH HISTORY & CHART NOTES**



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## 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 (L33803). 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.



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