# Incontinence Supplies
## Standard Written Order (SWO)

Order Date: _____

**Prism Health Care Services, Inc.**
**1337 Basswood Road**
**Schaumburg, IL 60173-4353**
**Phone: 847-310-4730**
**Fax: 872-469-1673**

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Medicaid ID #: _____ Discharge Date: _____

Delivery Address: _____

Facility: _____

## Qualifying Incontinence Diagnosis (required) check all that apply

☐ **N39.41** Urge incontinence
☐ **R32** Unspecified urinary incontinence
☐ **N39.46** Mixed urinary incontinence (stress + urge)
☐ **R15.9** Full incontinence of feces
☐ **N39.498** Other specified urinary incontinence
☐ **R39.81** Functional urinary incontinence
☐ **Other incontinence diagnosis:** _____

*Dementia, CVA, Parkinson's, weakness, or limited mobility do not qualify alone — the incontinence itself must be documented and coded.*

## Payer — Medicaid must be the payer for incontinence supplies

☐ Straight Medicaid ☐ Medicare primary + Medicaid secondary ☐ Medicaid Managed Care (MCO) — select plan:
☐ Aetna Better Health of IL ☐ BCBSIL Community Health Plans ☐ CountyCare ☐ Meridian ☐ YouthCare

*Not eligible: dual-eligible LTC residents, hospice, commercial plans, Medicare/MA with commercial secondary, Molina (not contracted).*

## Select products, size, and quantity

| Product | Size | Qty / Month | Monthly Max | Changes / Day |
|---|---|---|---|---|
| ☐ Adult Brief (Nu-Fit Brief) | ☐ M ☐ L ☐ XL ☐ XXL | _____ | **200*** | _____ |
| ☐ Pull-On Underwear (Nu-Fit Pull-On) | ☐ M ☐ L ☐ XL ☐ XXL | _____ | **200*** | _____ |
| ☐ Disposable Underpads | 23” x 36” | _____ | **150** | _____ |
| ☐ Gloves, Non-Sterile | ☐ M ☐ L ☐ Other: ____ | _____ | **200** | N/A |

** Briefs and pull-ons combined may not exceed 200 per month. Quantities are counted in each, not cases. Order to assessed need.*

| Waist / Hip (in.) | Medium | Large | X-Large | XX-Large | Measured waist / hip (widest point): _____ in. |
|---|---|---|---|---|---|
| **Nu-Fit Brief** | 32–44" | 45–58" | 59–64" | 62–73" | *When between sizes, choose the larger.* |
| **Nu-Fit Pull-On** | 34–46" | 44–58" | 58–68" | 68–80" | Length of Need: ☐ 12 mo ☐ 99 mo (lifetime) |

**PLEASE SUBMIT THIS FORM ALONG WITH CLINICAL NOTES, i.e., doctors, progress, and nurses’ notes. The notes must document the incontinence diagnosis and the need for the supplies. Also, it is required that the date of this form be the same or after the date on the Clinical Notes.**

**The following criteria must be met for the above selected items to be covered,**
**(per Prism Health Care Services incontinence program eligibility guidelines)**

## Coverage Criteria

| | | |
|---|---|---|
| Diagnosis | 1 | The patient has a documented qualifying incontinence diagnosis (ICD-10-CM code selected above), AND |
| Payer | 2 | Medicaid is the payer (straight Medicaid, Medicare w/ Medicaid secondary, or contracted MCO), AND |
| Care Setting | 3 | The patient is not a dual-eligible long-term care resident or a hospice patient, AND |
| Quantity | 4 | Quantities reflect assessed need and do not exceed the Medicaid monthly maximums. |

**If the criteria are not met, or proper documentation is not received, the incontinence supplies will be denied as not medically necessary.**

**Physician Name:** _____ **NPI:** _____

**Physician Signature:** _____ **Date:** _____

**Physician Phone:** _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.