Better Living Now

Ostomy Supplies

Instructions: Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

Order Form

Referral source (i.e. physician, website)	Follow-up on order status with	Order Date
Referral source name	Best day to follow-up	Phone
Referral relation to patient	Best time to follow-up	Email

Patient

Name
BLN account-seq #
Marital status
DOB
Sex
Age

Bill to address
City
Phone / E-mail
State Zip
County

Emergency contact
Relationship to patient
Emergency phone
Emergency email

Physician

Physician name
Phone / Email
Company
Fax

Physician address
City
State Zip

DEA #
NPI #
State license #

For Physician Use Only: Physician Stamp

Physician Stamp:

For Physician Use Only: Prescription

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX

Dispense As Written ☐

Dispense
☐ 1 Month Supply ☐ 3 Month Supply

Products

Quantity			HCPCS Code
Quantity	Pouch ☐ One Piece ☐ Two Piece	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Flange w/ Skin Barrier to use with Two Piece Pouch (box)	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Skin Barrier 2 oz (each) ☐ Paste ☐ Powder	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Skin Prep Wipes (box)	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Adhesive Remover Wipes (box)	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Skin Barrier Wafer Solid (box) ☐ 4" x 4" ☐ 6" x 6" ☐ 8" x 8"	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Tape (roll) ☐ Paper ☐ Cloth ☐ Waterproof ☐ 1" ☐ 2" ☐ 3"	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Night Urinary Drainage Collector (each)	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	Bedside Urinary Drainage Bag 2000cc	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	NDC #, catalog # or product description	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code

Diagnosis

☐ K94.00 Colostomy complication, unspecified
☐ K94.10 Enterostomy complication, unspecified
☐ K94.03 Colostomy malfunction
☐ K94.13 Enterostomy malfunction
☐ Z93.2 Ileostomy status
☐ Z93.3 Colostomy status
☐ Z93.6 Other artificial openings of urinary tract status
☐ Z43.2 Encounter for attention to ileostomy
☐ Z43.3 Encounter for attention to colostomy
☐ Z43.6 Encounter for attention to other artificial openings of urinary tract

☐ Other (Prognosis and size of stoma)

Questions

Do you have allergies to products applied to the skin?
☐ Yes. If yes, please list.
☐ No

Allergies to Latex?
☐ Yes. If yes, please list.
☐ No

Primary Medical Insurance

Plan Name
ID #
Group Name
Effective Date

Relationship to member
☐ Self (check and skip section)
☐ Spouse ☐ Child
Member name
DOB
Member ID #

Secondary Medical Insurance

Plan Name
ID #
Group Name
Effective Date

Relationship to member
☐ Self (check and skip section)
☐ Spouse ☐ Child
Member name
DOB
Member ID #

Primary Pharmacy Insurance

Plan Name
ID #
Group #
BIN #
PCN #

Relationship to insured
☐ Member ☐ Spouse ☐ Child
Person Code

Secondary Pharmacy Insurance

Plan Name
ID #
Group #
BIN #
PCN #

Relationship to insured
☐ Member ☐ Spouse ☐ Child
Person Code

Additional Comments

Shipping / Delivery ☐ Expedite

☐ BLN Best Method
☐ UPS ☐ Ground
☐ USPS ☐ Next Day ☐ Second Day
☐ Other _____

Ship to address ☐ Same as bill to address

Payment

☐ Check
☐ Mastercard ☐ Visa
☐ American Express ☐ Discover

Name on Credit Card

Credit Card Number

Credit Card Expiration Date

For Office Use Only: Routing

Initial	Routed to	Initial	Requested to
	Order Processing ☐ Pharmacy Date mm / dd / yy		Database Management Date mm / dd / yy
	Documentation Date mm / dd / yy		Management Date mm / dd / yy
	Insurance Verification Date mm / dd / yy		New Client / Group Entry Date mm / dd / yy
	Shipping Date mm / dd / yy		Other Date mm / dd / yy

For Office Use Only: Notes

Better Living Now, Inc.
185 Oser Ave.
Hauppauge, NY 11788

Instructions - Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN.
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1) Patient

a) Please complete the Member section of the order form on the reverse side indicating the insurance you have that provides coverage for your Ostomy Supplies.

2) Doctor

a) Please complete the patient information and doctor information sections.
b) Please indicate the products you want supplied to the patient, with directions for use and quantity required;
c) Please sign and date on the spaces provided.

3) Some Medicare Coverage Rules that should be noted:

a) Medicare reimbursement limits Ostomy Supplies to a three (3) months supply at one time.
b) If treatment regimen exceeds the quantity limitations noted below, then Medicare requires a Letter of Medical Necessity signed by the physician on his or her letterhead.
c) If you fax this document, Medicare/insurance requirements are that you maintain the signed original in the patient's medical record for post-payment review audit purposes.

4) Medicare Guidelines for Ostomy Supplies

Note: Monthly allowable amounts do not represent a benefit limit. The actual quantity needed by a particular customer may be more or less than the amount listed, depending on the individual customer's medical condition. Customers ordering over the allowable amount must have appropriate medical justification (i.e. a letter of medical necessity)

Effective 01/01/2003	Quantity Limitations	Effective 01/01/2003	Quantity Limitations
Adhesives and Adhesive Removers		Other	
Adhesive (Cement), Liquid Or Equal, Any Type, Per Oz (A4364)	4 oz per month	Appliance Cleaner, Incontinence And Ostomy Appliances, Per 16 Oz. (A5131)	16 oz per month
Adhesive Remover Or Solvent (For Tape, Cement Or Other Adhesive), Per Ounce (A4455)	8 oz per 3 months 16 oz per 6 months	Bedside Drainage Bag, Day Or Night, With Or Without Anti-Reflux Device, With or Without Tube, Each (A4357)	2 ea per month
Adhesive Or Non-Adhesive; Disk Or Foam Pad (A5126)	20 per month	Bedside Drainage Bottle With Or Without Tubing, Rigid Or Expandable, Each (A5102)	1 ea every 3 months 2 ea every 6 months
Pouches		Belt, Ostomy (A4367)	1 ea per month
Ostomy Pouch, Closed (A5051, A5052, A5053, A5054)	Up to 60 per month	Continent Device; Catheter For Continent Stoma (A5082)	1 per month
Ostomy Pouch, Drainable – 2 piece (A5063)	Up to 20 per month	Continent Device; Plug For Continent Stoma (A5081)	31 per month
Ostomy Pouch, Drainable – 1 piece (A5062, K0567, K0568)	Up to 20 per month	Gauze, Non-Impregnated, Non-Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing (A6216)	60 per month
Ostomy Pouch, Drainable, For Use On Faceplate, Plastic, Each (A4377)	10 per month	Irrigation Supply; Sleeve, Each (A4397)	4 per month
Ostomy Pouch, Urinary, For Use On Faceplate, Plastic, Each (A4381)	10 per month	Lubricant, Per Ounce (A4402)	4 oz per month
Ostomy Pouch, Urinary – 2 piece (A5073)	20 per month	Ostomy Accessory; Convex Insert (A5093)	10 per month
Ostomy Pouch, Urinary – 1 piece (A5071, A5072)	20 per month	Ostomy Faceplate, Each (A4361)	3 per 6 months
Wafers/Flanges		Ostomy Irrigation Supply; Bag, Each (A4398)	2 per 6 months
Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion) (K0570, K0571, A4414, A4415)	20 per month	Ostomy Ring, Each (A4404)	10 per month
Skin Barrier; Solid, 4"x4", 6"x6", or 8"x8" (A4362, A5121, A5122)	20 per month	Stoma Cap (A5055)	31 per month
Skin Barriers		Tape, per 18 Square Inches (A4450, A4452)	Varies by region. Approx. 2 rolls of 1" tape per month
Ostomy Skin Barrier, Liquid (Spray, Brush, Etc), Per Oz (A4369)	2 oz per month		
Ostomy Skin Barrier, Paste, Per Ounce (K0561, K0562, A4405, A4406)	4 oz per month		
Ostomy Skin Barrier, Powder, Per Oz (A4371)	5 oz per 3 months 10 oz per 6 months		
Skin Barrier; Wipes, Box per 50 (A5119)	150 per 6 months		