200 PHARMACY
& MEDICAL SUPPLIES

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Chicago, IL 60617
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CATHETER/ FOLEY – CERTIFICATE OF MEDICAL NECESSITY

MEDICARE/MEDICAID requires a certifying physician signature for Catheter/ Foley supplies. Please fill out where indicated by asterisk and return via fax/mail.

Patients Name: _____ D.O.B: _____

Patients Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ ☐ FEMALE ☐ MALE

Medicare #: _____ Medicaid #: _____Other: _____

Diagnosis: _____

PLEASE CHECK ITEMS – CIRCLE SIZES:

- ☐ CATHETER (TEXAS Male External)
  - SIZE: ____ SM ____M ____INTER ____LARGE ____X-LARGE
    QTY: MEDICARE ALLOWS 35/MONTH: _____
- ☐ STRAIGHT CATHETER TYPE: _____
  QTY: _____
- ☐ FOLEY CATHETER : 2-WAY LATEX SILOCONE COATING BALOON SIZE: ____ 5CC OR ____30CC
  - SIZE: ____12FR ____14FR ____16 FR ____18FR ____20FR ____26FR
    ____28FR ____30FR
- ☐ INTERMITTENT RED RUBBER SIZE: ____10FR ____12FR ____14FR ____16FR
  ____18FR
- ☐ URINARY DRAINAGE BAGS (QUANTITY 1 OR 2)
- ☐ URINARY LEG BAGS (QUANTITY 1 OR 2)
- ☐ Lubricant
- ☐ OTHER: _____

REFILLS: 1 2 3 4 5 6 MONTHS 1 YEAR (CIRCLE ONE)

- ✓ **YES THIS PATIENT REQUIRES THE ABOVE SUPPLIES**

Physician Name: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

YOUR PROMPT RESPONSE IS MOST APPRECIATED