



FAX to 1-888-844-0528 or 334-821-2033

Phone 1-888-303-1164

Website [www.allsouthservices.com](http://www.allsouthservices.com)

| PATIENT INFORMATION |             |   |                  |   |
|---------------------|-------------|---|------------------|---|
| Last Name           |             | First Name  |                  | DOB   |
| Street              |             | City  | St.              | Zip   |
| Phone               |             | SS#   | Sex              |   |
| Primary Insurance   |             |   | Insurance I.D. # |   |
| RX                  |             | MEDICAL JUSTIFICATION                               |                  |   |
| QTY                 | SIZE        | DESCRIPTION   | BRAND            |   |
|                     |             | <b>Urology Supplies</b>                             |                  | <b>RX START DATE:</b> _____   |
|                     |             | Intermittent straight catheters                     |                  | <b>LENGTH OF NEED:</b> <input type="checkbox"/> 99 = Lifetime               |
|                     |             | Intermittent coude catheters                        |                  | <input type="checkbox"/> Other  |
|                     |             | Intermittent hydrophilic cath.                      |                  | <b>ORDER NOTES</b>  |
|                     |             | Intermittent closed system w/<br>Insertion supplies |                  | _____   |
|                     |             | Foley catheters                                     |                  | <b>DIAGNOSIS</b>  |
|                     |             | Foley catheter insertion trays                      |                  | <input type="checkbox"/> 788.30 Permanent Urinary Incontinence              |
|                     |             | Irrigation trays                                    |                  | <input type="checkbox"/> 788.20 Permanent Urinary Retention                 |
|                     |             | Male external catheters                             |                  | <input type="checkbox"/> 599.6 Urinary Retention                            |
|                     |             | Night bedside drainage bags                         |                  | <input type="checkbox"/> 344.61 Neurogenic Bladder                          |
|                     |             | Leg bags  |                  | <input type="checkbox"/> 344.1 Paraplegia                                   |
|                     |             | Leg bag strap                                       |                  | <input type="checkbox"/> 344.0 Quadraplegia                                 |
|                     |             | Lubricating packets                                 |                  | <input type="checkbox"/> 741.90 Spina Bifida                                |
|                     |             | Lubricating tube                                    |                  | <input type="checkbox"/> 340 Multiple Sclerosis                             |
|                     |             | Gloves  |                  | <input type="checkbox"/> V44.2 Ileostomy                                    |
|                     |             | Other   |                  | <input type="checkbox"/> V44.3 Colostomy                                    |
|                     |             | <b>Diabetes Supplies</b>                            |                  | <input type="checkbox"/> V44.6 Urostomy                                     |
|                     |             | Meter   |                  | <input type="checkbox"/> 707.00 Decubitus Ulcer                             |
|                     |             | Strips  |                  | <input type="checkbox"/> 250.01 Juvenile type not stated as uncontrolled    |
|                     |             | Lancets   |                  | <input type="checkbox"/> 250.00 Unspecified type not stated as uncontrolled |
|                     |             | Lancet Device                                       |                  | <input type="checkbox"/> Other _____  |
|                     |             | Control Solution                                    |                  | _____   |
|                     |             | Battery   |                  |   |
|                     |             | Other   |                  |   |
|                     |             | <b>Incontinence Supplies</b>                        |                  | <b>ASSIGNMENT OF BENEFITS</b>   |
|                     |             | Adult briefs  |                  | (All South Services is HIPAA compliant) I request that payment of my        |
|                     |             | Adult pull ups                                      |                  | Insurance benefits (Medicare, Medicaid, Medicare Supplemental or            |
|                     |             | Adult undergarments                                 |                  | other) be made to All South Services for any supplies or services           |
|                     |             | Children diapers                                    |                  | furnished to me by All South Services. I am responsible to pay all          |
|                     |             | Children pull ups                                   |                  | amounts that are not covered by my insurance. I authorize any holder        |
|                     |             | Children training pants                             |                  | of medical information about me to release to All South Services any        |
|                     |             | Underpads   |                  | information needed to determine benefits payable for these supplies or      |
|                     |             | Gloves  |                  | services. I authorize All South Services to release my medical records      |
|                     |             | Wipes   |                  | to insurers as well as medical professionals in my care and/or make         |
|                     |             | <b>Ostomy Supplies</b>                              |                  | said copies. I authorize All South Services to contact me by telephone,     |
|                     |             | 1pce Pouch  |                  | email, or mail regarding my medical supplies.                               |
|                     |             | 2pce Pouch  |                  | _____   |
|                     |             | Wafer/Flange  |                  | Patient Signature   |
|                     |             | Skin prep   |                  | <b>PHYSICIAN'S INFORMATION</b>  |
|                     |             | Adhesive remover                                    |                  | Physician's Name _____  |
|                     |             | Paste   |                  | Address _____   |
|                     |             | Deodorizer  |                  | City/State/Zip _____  |
|                     |             | Other   |                  | UPIN # _____ Phone _____  |
|                     |             | <b>Wound Care Supplies</b>                          |                  | _____   |
|                     |             | Gauze   |                  | Physician's Signature _____ Date _____                                      |
|                     |             | Calcium Alginate                                    |                  |   |
|                     |             | Collagen  |                  |   |
|                     |             | Foam  |                  |   |
|                     |             | Hydrocolloid  |                  |   |
|                     |             | Hydrogel  |                  |   |
|                     |             | ABD Pads  |                  |   |
|                     |             | Tape  |                  |   |
|                     |             | Conform Roll  |                  |   |
|                     | 2x2         | Other TheraGauze                                    |                  |   |
|                     | 4.125x4.125 | TheraGauze  |                  |   |