STYMCO MEDICAL

(844) 552-8813 • www.STYMCO.com

TO PLACE THIS ORDER...
Fax to (813) 922-3152 OR
Email to verify@stymco.com

☑ **Completed Prescription Form**

Patient Insurance & Address

Relevant Medical Notes

Ostomy Prescription Form

PATIENT INFORMATION

Patient Name: _____

DOB: _____ ☐ Male ☐ Female

Is the patient being seen by home health services? ☐ Yes ☐ No

Has patient been notified of and chosen STYMCO for this order? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Start Date: _____ Length of Need *(months)*: _____

Dispense *(days)*: ☐ 30 ☐ 60 ☐ 90 Number of Refills: _____

Order Type: ☐ NEW *(replace existing)* ☐ ADD *(supplement existing)*

Has patient been trained to use the prescribed equipment? ☐ Yes ☐ No

PRIMARY DIAGNOSIS *(REQUIRED)*

☐ Z93.3 - Colostomy ☐ Z93.2 - Ileostomy ☐ Z93.6 - Urostomy ☐ Z43.2 - Encounter for Ileostomy ☐ Z43.6 - Encounter for Urostomy ☐ Other:_____

PREFERRED PRODUCT MANUFACTURER / BRAND

☐ Hollister ☐ Convatec ☐ Coloplast ☐ Genairex ☐ Other: _____

OSTOMY PRODUCTS

PRODUCT TYPE	PRODUCT OPTIONS	BRAND / ITEM #	QTY / DAY	FREQ
☐ One Piece Pouch	☐ Closed ☐ Drainable ☐ Urostomy			
☐ Two Piece Pouch*	☐ Closed ☐ Drainable ☐ Urostomy			
☐ Flange w/ Skin Barrier **(Req. for Two Piece Pouch)*				
☐ Tape	☐ 2" Cloth ☐ 2" Medipore			
☐ Skin Prep Wipes *(Box)*				
☐ Adhesive Remover Wipes *(Box)*				
☐ Paste *(2 oz.)*				
☐ Strip Paste				
☐ Elastic Barrier Strips				
☐ Deodorant	☐ Packets ☐ 8 oz. Bottle			
☐ Adhesive Ring	Size:			
☐ Barrier Ring	☐ 2" ☐ 4"			
☐ Wafer	☐ 4" x 4" ☐ 6" x 6"			
☐ Bedside Urinary Drainage Bag	☐ 2000 ml ☐ Urinary Drainage Bottle			
☐ Decrystalizer / Cleaner				
☐ Powder *(1 oz.)*				
☐ Ostomy Belt	☐ Medium ☐ Large			
Other:				

PRESCRIBER INFORMATION / APPROVAL

I, the undersigned, certify that this order is reasonable and medically necessary or it is a mandated benefit. This document is also written in the patient's record. The forgoing information is true, accurate, and complete. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**

Prescriber Name *(Please Print)*: _____ Facility Name: _____

Facility City/State: _____ Phone: _____ Fax: _____

SIGNATURE: _____ **Date:** _____ **NPI#:** _____

This form is designed to initiate a new order for products. Some payers may require STYMCO to verify this order or obtain prior authorization before the order can be shipped.

STYMCO is providing HCPCS/CPT codes based on information provided by the product manufacturers. STYMCO does not make representations about the accuracy of this information. The HCPCS/CPT codes do not indicate coverage or payment under any federal or state health care program. The entity that submits claims to any federal or state health care program has the responsibility to verify the accuracy of HCPCS/CPT codes it submits for payment purposes.

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