uricap
Female

Company:
Address:
Phone:
Fax:

Letter of Medical Necessity
Fax Completed Form with Addendum to Medical Records to ___-_____

Patient Info

Per _____ a dispensing order was completed with a physician order start date:_____

Patient Name: _____
DOB: _____
Phone: _____
Address: _____
City: _____
State: _____
ZIP: _____

Primary Insurance: _____
Primary Insurance ID Number: _____
Primary Insurance Phone Number: _____
Secondary Insurance: _____
Secondary Insurance ID Number: _____
Secondary Insurance Phone Number: _____

ICD 10

- ☐ **R32: Unspecified Urinary Incontinence (788.30)**
- ☐ **N39.43: Post Void Dribbling (788.35)**
- ☐ **N39.41: Urge Incontinence (788.31)**
- ☐ **N39.44: Nocturnal Enuresis (788.36)**
- ☐ **N39.3: Stress Incontinence (788.32)**
- ☐ **N39.46: Mixed Incontinence (788.33)**
- ☐ **N39.45: Continuous Leakage (788.37)**
- ☐ **N39.498: Other Specified Urinary Incontinence (788.39)**

Please attach Medical Records Supporting patient has been incontinent for 3 months or longer.

Plan of Care

I certify the medical necessity of UriCap Female as the required therapy for this patient. Due to the patient's permanent condition and because other methods will not provide acceptable results, there is sufficient case evidence that UriCap has produced repeated successful results with other patients.
I prescribe the UriCap Female to be dispensed as follows:

Duration of Need: 99 Refills
- ✓ **UriCap: 35 units/month or 90 units/3 months (A4328)**
- ✓ **Leg Bag: 2 units/month or 6 units/3 months (A4358)**
- ✓ **Bed Bag: 2 units/month or 6 units/3 months (A4357)**

Physician: _____
UPIN/NPI: _____
Office Phone: _____
Physician Signature: _____
Date: _____
Signature Stamps are NOT accepted
If electronically signed, must be noted so

The patient listed above has contacted TillaCare to request a supply of UriCap Female devices listed on this Letter of Medical Necessity. The patient has also been informed and has acknowledged that either a distributor listed below or another partnering distributor will be contacting them in order to process the shipment.

Fax Signed Completed Form with Addendum to Medical Records to ___-_____

Company:
Address:
Phone:
Fax: