SALES | SERVICE | RENTALS
2301-A Crownpoint Executive Dr.
Charlotte, NC 28227
Office/Fax 704-821-7777
www.ShopMobility.com

FAX COVER PAGE / DME ORDER REQUEST

Date:	Total Pages:
To:	From:
Fax:	Patient:
Phone:	Date of Birth:

Urgent	For Review	Please Reply

Dear Physician,
We have been asked to provide incontinence supplies to your patient named above. Medicaid requires that you complete the attached CMN and Order Form so that we can provide these supplies. On behalf of this patient, we are requesting your completion of the attached. Please explain the medical necessity for these supplies on question #30 of the CMN and in the patient's chart notes. ***Please fax both the CMN/PA Form and Order Form back along with the relative patient chart notes.*** *Thank you for your cooperation and prompt response. We greatly appreciate your assistance in providing for this patient!*

PLEASE COMPLETE ALL HIGHLIGHTED AREAS, SIGN AND FAX BACK
with RELATIVE CHART NOTES TO (FAX)# 704-821-7777
QUESTIONS PLEASE CALL 704-821-7777 Ext 101

YOU DO NOT NEED TO FAX BACK THIS COVER PAGE

Incontinence Supplies Order Form

Referral Source:			Consultant: Jay Buinicky		
Phone #			Phone #		
Patient Demographics					
Name:			Phone:		
Street Address:			City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	Social Security #:	

Insurance Information	
Primary Insurance Information: ❑ Medicare ❑ Medicaid	Secondary Insurance Information: ❑ Medicare ❑ Medicaid
Name:	Name:
Address:	Address:
Phone:	Phone:
Policy #:	Policy #:

SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS			
1.	**2.**	**3.**	**4.**

DESCRIPTION OF ITEM	HCPCS CODE	QUANTITY
Adult Briefs/Pull Ups	**Code _____ Circle Size Below Small Medium Large XL**	**Up to 200 per month**
Underpads	**A4554**	**Up to 150 per month**
Gloves	**A4927**	**Up to 4 boxes per month**
Adult Wipes	**A4335**	**Up to 4 boxes per month**

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the above prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patients well being, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physician Name:		**NPI #:**	
Address:	**City:**	**State:**	**Zip:**
Contact:	**Phone:**	**Fax:**	
Physician Signature:		**Date:**	

Fax to 704-821-7777 or email to info@mobility-more.com

NC DMA Request for Prior Approval CMN/PA

Recipient Information **DMA372-131**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☒ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____ NPI: ☒ Atypical: ☐ 8. Taxonomy: _____
9. Address: _____ 10. Nine Digit Zip Code: _____
11. Billing Provider # (if different from requesting): 1043725104 NPI: ☒ Atypical: ☐ 12. Taxonomy: 332BX2000X
13. Address: 2301-A Crownpoint Executive Dr. Charlotte, NC 14. Nine Digit Zip Code: 28227
15. Rendering Provider # (if different from billing):_____ NPI: ☐ Atypical: ☐ 16. Taxonomy: _____
17. Address: _____ 18. Nine Digit Zip Code: _____
Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Medical and Functional Status

19. **Condition:** Stable: ☐ Unstable: ☐ Height: _____ Weight: _____
20. **Prognosis:** Terminal: ☐ Poor: ☐ Guarded: ☐ Fair: ☐ Good: ☐ Excellent: ☐
21. **Patient:** Requires positioning not feasible in ordinary bed: ☐ Unattended for long periods of time: ☐ Lives alone: ☐
22. **Equipment:** Necessary to retard deterioration of condition: ☐ Necessary for function: ☐ Specify_____ Length of need: _____
23. **Mental:** Oriented: ☐ Forgetful: ☐ Disoriented: ☐ Agitated: ☐ Comatose: ☐ Depressed: ☐ Lethargic: ☐ Infant: ☐ Other: _____
24. **Neurological:** Muscle Tone: Normal: ☐ Increased: ☐ Decreased: ☐ Fluctuating: ☐
Sensation: Normal: ☐ Abnormal: ☐ Specify:_____
25. **Respiratory:** Normal: ☐ SOB on minimal exertion: ☐ Tracheostomy: ☐
O2: ☐ Flow Rate:_____ Frequency: _____ Test Date: _____ Results: _____
26. **Skin:** Normal: ☐ Other: ☐ Specify: _____ Decubiti: ☐ Specify: _____
27. **Ambulatory:** Complete bedrest: ☐ Up as tolerated: ☐
Transfers bed-chair (indep): ☐ Transfers bed-chair (w/assistance): ☐ Confined to wheelchair? ☐ Hours per day: _____
Walks unassisted: ☐ Walks with assistive device: ☐ Specify: _____ Max distance walked: _____
28. Can place of residence physically accommodate equipment being requested? ☐ Yes ☐ No
29. Patient's status will be monitored by physician while assistance is provided? ☐ Yes ☐ No
30. Medical Necessity of equipment: _____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1	1/2/25	12/31/25	New	T4527	Protective Underwear
2	1/2/25	12/31/25	New	A4554	Underpads
3	1/2/25	12/31/25	New	A4927	Gloves up to 4 boxes per month
4	1/2/25	12/31/25	New	A4335	Wipes up to 4 boxes of 50 per month
5	1/2/25	12/31/25	New	A4349	Condom Catheter - up to 35 per month
6	1/2/25	12/31/25	New	A4358	Beside Drainage Bags - up to 4 bags per month
7					
8					
9					
10					

Jay Bunicky 1/2/25
Requesting Provider's Signature Date Physician, PA, Nurse Practitioner Signature Date