PureWick™ System & External Wicks Authorization Form

Form must be **manually signed** then faxed to (805)334-3424.

RA FISCHER CO.

Ph: (800)525-3467 | Fax: (805)334-3424

Patient Information

Please Attach History and Chart Notes *Additional documentation may be requested to document medical necessity.*

Patient Name	Gender ☐ Female ☐ Male	Date of Birth (MM/DD/YY)

Street Address	City	State	ZIP

Phone Number	Email

Primary Insurance	Member ID #

Secondary Insurance	Member ID #

Supply Information

PUREWICK™ SYSTEM *Required

☐ PureWick™ Urine Collection System (E2001): ____ months ☐ For Lifetime Use

Note: Months are for short term use only

☐ PureWick™ Female Disposable External Catheters (A6590): ____ per month*

Note: Quanity 30 for overnight
Quantity 60 for 24 hour use

REPLACEMENT COMPONENTS

☐ PureWick™ 2000cc Collection Canister (A7001)

☐ PureWick™ Replacement Collector Tubing (A7002)

ICD CODES - DIAGNOSIS CODES

ICD-10-CM Code(s): _____

Physician Information

Physician Name	NPI	Tax ID

Office Name	Street Address	City	State	ZIP

Phone Number	Fax

LICENSED HEALTHCARE PROVIDER'S ACKNOWLEDGMENT

My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge.
I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that they will be contacted by RA Fischer regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

_____ _____

Provider Signature Date

PureWick™ System & External Wicks
Statement of Medical Necessity

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RA FISCHER CO.

Ph: (800)525-3467 | Fax: (805)334-3424

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____

Medicare Number: _____

DIAGNOSIS AND DURATION:

ICD-10-CM Code: _____

Duration: Lifetime, with reassessment annually or as needed based on patient's condition.

Date of Onset: _____

PRESCRIBING PHYSICIAN INFORMATION

Physician Name		NPI		
Office Name	Street Address	City	State	ZIP
Phone Number	Fax			

MEDICAL STATEMENT OF NECESSITY:

_____ (Patient's Name) has a diagnosis of _____ (ICD-10). These conditions significantly impair the ability to urinate effectively, leading to recurrent urinary tract infections (UTIs) and other complications.

Due to this condition, _____ (Patient's Name) requires the use of a urological device to manage their bladder function and prevent further complications.

PRESCRIBED EQUIPMENT:

(HCPCS E2001)Urological Device, Suction Pump:

- Description: A urological device, such as PureWick™ Urine Collection System , which is essential for the effective management of the patient's bladder function.
- Medical Necessity: The urological device is necessary to ensure the patient can empty their bladder effectively, reducing the risk of UTIs and improving overall quality of life. Without this device, the patient would likely face recurrent infections and increased medical complications.

(HCPCS A6590)Disposable Supplies: External Urinary Catheters, used with suction pump per month:

- **Description:** Disposable supplies, including but not limited to PureWick™ Female External Catheters, which are required in conjunction with the urological device.
- **Medical Necessity:** These disposable supplies are essential to maintain the hygiene and functionality of the urological device. Daily use is required to prevent infections and ensure proper device operation, thus safeguarding the patient's health.

SUMMARY OF CLINICAL EVALUATION:

[Include a summary of the patient's clinical evaluation, findings, and any relevant test results or imaging studies that support the need for the prescribed equipment]

PHYSICIAN'S CERTIFICATION

I certify that the prescribed urological device and disposable supplies are medically necessary for the treatment of the above-named patient's medical condition. I have reviewed the patient's medical history and conducted a thorough evaluation. The prescribed equipment is essential to the patient's treatment plan and cannot be met by any other means.

_____ Provider Signature

_____ Date