

**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 <input type="checkbox"/> Female <input type="checkbox"/> 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	
<input type="checkbox"/> PureWick™ Urine Collection System (E2001): _____ months	<input type="checkbox"/> For Lifetime Use Note: Months are for short term use only
<input type="checkbox"/> PureWick™ Female Disposable External Catheters (A6590): _____ per month*	Note: Quantity 30 for overnight Quantity 60 for 24 hour use
REPLACEMENT COMPONENTS	
<input type="checkbox"/> PureWick™ 2000cc Collection Canister (A7001)	
<input type="checkbox"/> 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
Phone Number	Fax			
LICENSED HEALTHCARE PROVIDER'S ACKNOWLEDGMENT				
<p>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.</p>				
_____ Provider Signature			_____ Date	

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PureWick™ System & External Wicks
Statement of Medical Necessity

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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: _____
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PRESCRIBING PHYSICIAN INFORMATION					
Physician Name			NPI		
Office Name	Street Address		City	State	ZIP
Phone Number			Fax		

MEDICAL STATEMENT OF NECESSITY:

_____ has a diagnosis of _____. These conditions significantly impair the ability to urinate effectively, leading to recurrent urinary tract infections (UTIs) and other complications.

Due to this condition, _____ 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

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