Male urinary incontinence

Request for funding

PATIENT INFORMATION

Last name	First name

Policy number

Name of insurer

Medical condition

- ☐ Quadriplegia
- ☐ Paraplegia
- ☐ Multiple Sclerosis
- ☐ Spina Bifida
- ☐ Prostatectomy
- ☐ Benign Prostatic Hyperplasia
- ☐ Diabetes
- ☐ Bladder Cancer
- ☐ Other: _____

PHYSICIAN INFORMATION

Name	License number

Clinic stamp

INSURER REQUEST INFORMATION

Dear Insurer,

My patient (named herein) has been assessed as requiring external catheterization for management of incontinence, as a consequence of his medical condition.

This patient has experienced the following, which had a negative impact on his health condition and quality of life:

- ☐ Skin irritation
- ☐ Scab
- ☐ Urinary tract infections
- ☐ Leakages
- ☐ Other: _____

As a consequence, the products prescribed (see reverse side) are required for my patient.

We therefore request funding for these products.

ADDITIONAL INFORMATION

PHYSICIAN SIGNATURE

DATE (MM/DD/YYYY)

See reverse side

Rx INFORMATION

EXTERNAL CATHETERS	URINE BAGS
☐ Conveen® Optima Standard ☐ 25 mm (#22025) ☐ 28 mm (#22028) ☐ 30 mm (#22030) ☐ 35 mm (#22035) ☐ 40 mm (#22040) ☐ Conveen Optima Short ☐ 21 mm (#22121) ☐ 25 mm (#22125) ☐ 30 mm (#22130) ☐ 35 mm (#22135) ☐ Other: _____	☐ Conveen Active Leg Bag 250 mL/9 oz (#25501) ☐ Conveen Leg Bag 500 mL/17 oz (#5161) ☐ Conveen Leg Bag 750 mL/26 oz (#5167) ☐ Conveen Night Bag 2 L/68 oz (#21346) ☐ Other: _____
Repeats ☐ Change every 24 hours ☐ Other: _____	**Monthly quantity** ☐ 30 External Catheters ☐ 30 Leg Bags ☐ 30 Night Bags ☐ Other: _____

Please attach quotation from dealer.