

Letter of Medical Necessity – Fax Completed Form with Addendum to Medical Records to **888-920-9370**

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

- | | |
|---|---|
| <input type="checkbox"/> R32: Unspecified Urinary Incontinence (788.30) | <input type="checkbox"/> N39.3: Stress Incontinence (male) (788.32) |
| <input type="checkbox"/> N39.43: Post Void Dribbling (788.35) | <input type="checkbox"/> N39.46: Mixed Incontinence (788.33) |
| <input type="checkbox"/> N39.41: Urge Incontinence (788.31) | <input type="checkbox"/> N39.45: Continuous Leakage (788.37) |
| <input type="checkbox"/> N39.44: Nocturnal Enuresis (788.36) | <input type="checkbox"/> N39.498: Other Specified Urinary Incontinence (788.39) |

Need Medical Records

Below confirms medical reason patient is unable to use a condom catheter which is supported within the patient's medical record and that record is attached:

N4883 Acquired Buried Penis	Q5564 Hidden Penis
N4829 Other Inflammatory Disorders of Penis	N4889 Other Specified Disorders of Penis
N390 Urinary Tract Infection, site not specified	Other _____

Plan of Care

I certify the medical necessity of BioDerm's Men's Liberty 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 Liberty has produced repeated successful results with other patients. I prescribe the Men's Liberty to be dispensed as follows:

Duration of Need: 99 Refills

- Men's Liberty:** 35 units/month or 90 units/3 months (A4326)
- Bed Bag:** 2 units/month or 6 units/3 months (A4357)
- Penile Clamp:** 1 units/3 month (A4356)

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 BioDerm to request a supply of Men's Liberty 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. Men's Liberty supplies are available through the following distributors:

Wound Care Resources 4 Newbern Hwy, P.O. Box 155 Yorkville, TN 38389	CCS Medical 14255 49th Street North, Suite 301 Clearwater, FL 33762	American Medical Distribution 7300 124th Ave. North Largo, FL 33773 USA	Byram Healthcare 120 Bloomingdale Rd. White Plains NY, 10605	Edgepark 1810 Summit Commerce Park Twinsburg, OH 44087
---	--	--	---	---