BECN 20219012913

BINSON'S Medical Equipment & Supplies Since 1953

26834 Lawrence
Center Line, MI
48047
1-888-246-4447

Please Fax Completed Form To: 1-800-882-7071

Ostomy – Written Order

reset form

Patient Name _____ DOB _____ Account Number _____

Order Date _____ Length of Need, 99 (lifetime) or _____ months

Diagnosis _____

Pouch Options	**Item Number**	**Quantity Needed**
☐ 1 Piece Closed Pouch		☐ ____ / month
☐ 1 Piece Drainable Pouch w/ Flat Wafer		☐ ____ / month
☐ 1 Piece Pouch w/ Convex Wafer		☐ ____ / month
☐ 2 Piece Pouch w/ Convex Wafer		☐ ____ / month
☐ 2 Piece Pouch w/ Flat Wafer		☐ ____ / month
☐ 2 Piece Closed Pouch System		☐ ____ / month
☐ Stoma Cap		☐ ____ / month
☐ Other _____		☐ ____ / month

Accessories	**Item Number**	**Quantity Needed**
☐ Paste		☐ ____ / month
☐ Barrier Rings		☐ ____ / month
☐ Remover Wipes		☐ ____ / month
☐ Barrier Prep Wipes		☐ ____ / month
☐ Lubricating Deodorant		☐ ____ / month
☐ Belt		☐ ____ / month
☐ Barrier Strips		☐ ____ / month
☐ Other _____		☐ ____ / month

****Required For *MICHIGAN* Medicaid Patients Only ****

Reason for Medical Necessity (other than diagnosis): _____

Prescribers Printed Name & Credentials _____ **NPI** _____

Phone _____ **Fax** _____

Signature _____ **Date** _____

2/29/2024

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