ALL SOUTH SERVICES, INC.

FAX to 1-888-844-0528 or 334-821-2033

Phone 1-888-303-1164

Website www.allsouthservices.com

PATIENT INFORMATION

Last Name	First Name		DOB
Street	City	St.	Zip
Phone	SS#	Sex	
Primary Insurance		Insurance I.D. #	

RX

QTY	SIZE	DESCRIPTION	BRAND
		Urology Supplies	
		Intermittent straight catheters	
		Intermittent coude catheters	
		Intermittent hydrophilic cath.	
		Intermittent closed system w/ Insertion supplies	
		Foley catheters	
		Foley catheter insertion trays	
		Irrigation trays	
		Male external catheters	
		Night bedside drainage bags	
		Leg bags	
		Leg bag strap	
		Lubricating packets	
		Lubricating tube	
		Gloves	
		Other	
		Diabetes Supplies	
		Meter	
		Strips	
		Lancets	
		Lancet Device	
		Control Solution	
		Battery	
		Other	
		Incontinence Supplies	
		Adult briefs	
		Adult pull ups	
		Adult undergarments	
		Children diapers	
		Children pull ups	
		Children training pants	
		Underpads	
		Gloves	
		Wipes	
		Ostomy Supplies	
		1pce Pouch	
		2pce Pouch	
		Wafer/Flange	
		Skin prep	
		Adhesive remover	
		Paste	
		Deodorizer	
		Other	
		Wound Care Supplies	
		Gauze	
		Calcium Alginate	
		Collagen	
		Foam	
		Hydrocolloid	
		Hydrogel	
		ABD Pads	
		Tape	
		Conform Roll	
	2X2 1oz.	Other Amerigel Saturated Gauze Amerigel Wound Dressing	

MEDICAL JUSTIFICATION

RX START DATE: _______________

LENGTH OF NEED: □ 99 = Lifetime
□ Other

ORDER NOTES

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DIAGNOSIS

□ 788.30 Permanent Urinary Incontinence
□ 788.20 Permanent Urinary Retention
□ 599.6 Urinary Retention
□ 344.61 Neurogenic Bladder
□ 344.1 Paraplegia
□ 344.0 Quadraplegia
□ 741.90 Spina Bifida
□ 340 Multiple Sclerosis
□ V44.2 Ileostomy
□ V44.3 Colostomy
□ V44.6 Urostomy
□ 707.00 Decubitus Ulcer
□ 250.01 Juvenile type not stated as uncontrolled
□ 250.00 Unspecified type not stated as uncontrolled
□ Other_____

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ASSIGNMENT OF BENEFITS

(All South Services is HIPAA compliant) I request that payment of my Insurance benefits (Medicare, Medicaid, Medicare Supplemental or other) be made to All South Services for any supplies or services furnished to me by All South Services. I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of medical information about me to release to All South Services any information needed to determine benefits payable for these supplies or services. I authorize All South Services to release my medical records to insurers as well as medical professionals in my care and/or make said copies. I authorize All South Services to contact me by telephone, email, or mail regarding my medical supplies.

_____

Patient Signature

PHYSICIAN'S INFORMATION

Physician's Name _____

Address _____

City/State/Zip _____

UPIN # _____ Phone _____

_____ _____

Physician's Signature Date