# LINK Program and Medical Prescription

BARD | CARE

**Please attach Patient Demographic Sheet, Insurance Card, Chart Notes and FAX to Bard Care at 800-859-5205**

**NAME** (required) _____ Gender ☐M ☐F DOB _____

Address _____ Spanish Speaking Only ☐

City, State, Zip _____ **PHONE** (required) _____

Primary Insurance _____ Secondary Insurance _____

**Duration of Need: 99 months (Lifetime) unless you specify otherwise here: _____**

## PRIMARY ICD-10 DIAGNOSIS CODE

Primary ICD-10 Diagnosis: (required)

- ☐ R33.9 Urinary retention; unspecified
- ☐ R32 Urinary incontinence; unspecified
- ☐ N39.41 Urge incontinence; unspecified
- Other _____

***For Coudé tip or intermittent catheter kits, please attach medical documentation to substantiate necessity.***

## INTERMITTENT CATHETERS

**FR Size** _____ (required)

**TIP** (required) ☐ Straight Tip ☐ Coudé Tip*

**LENGTH** ☐ Male ☐ Female ☐ Pediatric

**QUANTITY TO DISPENSE:** (required)

☐ 1/day (30/30 days) ☐ 2/day (60/30 days) ☐ 3/day (90/30 days) ☐ 4/day (120/30 days)
☐ 5/day (150/30 days) ☐ 6/day (180/30 days) ☐ Other _____ per day _____ per 30 days

### HYDROPHILIC

- ☐ Magic³® Hydrophilic w/SureGrip™
- ☐ Magic³ Go® Hydrophilic

### NON-HYDROPHILIC

- ☐ Magic³® All-Silicone
- ☐ CleanCath® Intermittent Catheter
- ☐ Red Rubber Intermittent Catheter
- ☐ BD™ Intermittent Catheter

### KITS

- ☐ Touchless® Plus System
- ☐ Bardia® Urethral Catheter and Tray

## ACCESSORIES & OTHER PRODUCTS

☐ Sterile Kit Components ☐ Lubricant Packets ☐ Lubricant Tube (4 oz./month) ☐ Other (List items below)

Other products: _____

**QUANTITY TO DISPENSE:** (required)

☐ 1/day (30/30 days) ☐ 2/day (60/30 days) ☐ 3/day (90/30 days) ☐ 4/day (120/30 days)
☐ 5/day (150/30 days) ☐ 6/day (180/30 days) ☐ Other _____ per day _____ per 30 days

## CLINICIAN INFORMATION

My signature below denotes that to the best of my knowledge the patient/caregiver is capable of using the ordered items which are designed for home use and is informed that he/she will be contacted by telephone from Bard Care and/or a medical equipment supplier regarding covered items ordered. The patient/caregiver has successfully completed training or is scheduled to begin training on the use of the supplies. I have informed the patient/caregiver of Bard Care's privacy policy.

**CLINICIAN'S SIGNATURE** (required) _____ **CLINICIAN'S NAME:** _____

**ORDER DATE** (required) _____/_____/_____ License # _____ NPI # _____

RN/MA Contact Name: _____ Phone: _____ Fax: _____

Address: _____ City _____ State_____ Zip:_____

Please consult product inserts and labels for any indications, contraindications, hazards, warnings, cautions and directions for use. As a manufacturer, we cannot instruct a provider how to bill. We can only provide possible codes that may be appropriate for the activities performed on a particular patient on a particular date of service. The provider of service must ascertain which codes are appropriate for the activities actually performed and those activities must be fully supported by detailed notes in the patient's medical record.

Bardia, CleanCath, Magic³, Magic³ GO, SureGrip, Touchless and BD are trademarks and/or registered trademarks of C. R. Bard, Inc. ©2020 C. R. Bard, Inc. All Rights Reserved. ICD-10 coding is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. 2008-19a BD-20616

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***For Coudé Tip and 100% Silicone Foley Catheters, please provide documentation supporting the medical necessity.***

## MALE EXTERNAL SELECTION

**QUANTITY TO DISPENSE:** (required) ☐ 35/mth (35/30 days) ☐ Other _____ per day _____ per 30 days

**TYPE OF CATHETER** ☐ Spirit® MEC Style 1 ☐ Spirit® MEC Style ☐ Spirit® MEC Style 3 ☐ The Natural® MEC

**CATHETER SIZE** ☐ 2 Small 25mm ☐ Medium 29mm ☐ Intermediate 32mm ☐ Large 36mm ☐ X-Drain Large 41mm

Leg Bag Kit ☐ 19 oz ☐ 32 oz (2/30 days) Other_____ ☐ Bag (2000 mL) (2/30 days) Other_____

## FOLEY CATHETER SELECTION

**QUANTITY TO DISPENSE:** (required) ☐ 1/mth (1/30 days) ☐ Other _____ per month _____ per 30 days

**TYPE OF CATHETER** ☐ Bard® Latex Foley Catheter ☐ Bard® Silicone Foley Catheter

**FR Size** _____(required) **TIP** (required) ☐ Straight Tip ☐ Coudé Tip* **BALLOON SIZE** ☐ 1.5cc ☐ 3cc ☐ 5cc ☐ 30cc

- ☐ Leg Bag Kit ☐ 9 oz ☐ 32 oz (2 /30 days) Other_____
- ☐ Drain Bag (2000 mL) (2/30 days) Other_____
- ☐ Foley Insertion Kit (2/30 days) Other_____
- ☐ Foley Catheter Anchoring Device (1/30 days) Other_____
- ☐ Stat Lock (12/30 days) Other_____

Other products: _____

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