How to Order

Your Starter Kit

1. Fill in your information
2. Sign the form
3. Fill out the order form
4. Have your Physician complete and sign the prescription form and Letter of Medical Necessity
5. Mail or fax this completed and signed form AND **copies of your insurance card** (front and back) to: Omni Medical Systems

To be completed by patient

1. Patient Information

Patient's Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____

Phone #: _____

TRICARE Policy #: _____

2. Assignment of Benefits

I authorize Omni Medical Systems to submit insurance claims on my behalf. I understand that I am financially responsible to Omni for any charages not covered by health care benefits.

(Patient signature is required)

Signature: _____

Date: _____

3. Order Form

Order: ☐ AMXDrnax™ Starter Kit

Gender: ☐ Male ☐ Female

Undergarment: ☐ Medium ☐ Large

To be completed by Physician

4. Prescription

The patient indicated below and on the previous page has been diagnosed with:

Code: ☐ 788.30 (Urinary Incontinence, Not Otherwise Specified)

☐ 596.59 (Other Function Disorders of the Bladder)

☐ Other Code: _____

Diagnosis: _____

Patient Name: _____

DOB: _____

Length of Need: ☐ Indefinite ☐ 12 months

Refills: Dispense as Necessary. Do not Substitute.

5. Letter of Medical Necessity

I have prescribed the AMXDrnax™ System and disposables. This prescription is for the urine collection system for managing the patient's urinary function and serves as the Letter of Medical Necessity. Dispense as written, fill as necessary, do not substitute.

Additional Medical Necessity Notes: _____

_____

_____

UPIN # _____

NPI # _____

License # _____

DEA # _____

Physician Name: _____

_____

Physician Signature: _____

Date: _____

Please Mail or Fax This Form to:

Omni Medical Systems
115 Catamount Drive, Milton, VT 05468
Phone: 1(888)709-2683; Fax: 1(802)891-5560