Please return completed form to DMEnsions at (248)-844-3824.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	

The monthly allowance for diapers is up to 192, based on member's growth and development, and their medical need. No prior auth needed.

Prior authorization and review for additional medical necessity is required for any quantity above 192 per month (based on 30 day supply), up to 300 diapers per month. The maximum allowed benefit is 300 diapers per month.

Please fax all requests for authorization of diapers for quantities > 192 and up to 300, to DMEnsion with this form completed by the ordering practitioner. Fax # 1-248-598-2121.

☐ Disposable underpads are limited to 150 per month (based on 30 day supply).

☐ DME vendors are prohibited from making automatic shipments.

Appeal Rights

Diaper quantities in excess of 300 per month and disposable underpads in excess of 150 per month are non-covered benefits. Benefit Appeal rights are explained in Neighborhood's Member Handbook. Appeals should be sent by member or their representative directly to Neighborhood's Customer Service department.

I. DIAGNOSIS

II. Member has received 192 diapers for dates of service _____ thru

☐ YES ☐ NO

III. How many more diapers greater than 192 does member need per month?

Note: Monthly total should not exceed 300.

Updated 7/2011, 7/2012, Reviewed 6/2013, 2/2016, 10/2016

IV. Clinical Information

A. Member is over the age of 3 years old and has the following symptoms and/or types of incontinence:

- ☐ Stress – urine loss caused by increased intra-abdominal pressure
- ☐ Urge – urine loss caused by involuntary bladder contraction
- ☐ Mixed – urine loss caused by a combination of stress and urge incontinence
- ☐ Overflow – urine loss when urine produced exceeds the bladder's holding capacity
- ☐ Total – uncontrolled or continuous leakage caused by neurological dysfunction, abdominal surgeries, or anatomical defects.

B. Prognosis

Estimated length of need _____ _ (number of months)

C. Date of last physical exam

Please identify any and all factors contributing to urinary incontinence, per the physical exam:

- ☐ Medical conditions, such as delayed developmental skills, fecal impaction, psychosis, or other neurological diseases that affect motor skills
- ☐ Symptomatic urinary tract infection
- ☐ Evidence of atrophic urethritis/vaginitis
- ☐ Medication regimens that include diuretics, drugs that stimulate or block the sympathetic nervous system, or psychoactive medications
- ☐ Environmental conditions (for example, impaired mobility, lack of access to a toilet, restraints, restrictive clothing, or excessive beverage intake)
- ☐ Social circumstances that prevent personal hygiene (for example, inconsistent caregiver support for toileting)

D. Please identify which tests have been conducted and document results

- ☐ Developmental assessment and prognosis in children
- ☐ Urinalysis/culture and sensitivity
- ☐ Urological testing and/or consultation
- ☐ Rectal exam
- ☐ Pelvic exam in women

Test Results _____

E. Please identify treatments (for example, behavioral techniques, pharmacologic therapy, and/or surgical intervention) to manage symptoms of incontinence which have been tried and failed or were partially Successful_____

Additional Information

- ☐ Urinary incontinence is accompanied by fecal incontinence.
- ☐ Enuresis due to a diagnosis of Global Delay and toilet training program is in place and is ongoing.

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	**Date:**

NEIGHBORHOOD DECISION ***Authorization is not a guarantee of payment.***		
Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	☐ **Not Approved - Letter to Follow**

Updated 7/2011, 7/2012, Reviewed 6/2013, 2/2016, 10/2016