Prescription/Letter of Medical Necessity for ***Bladder Leakage Urethral Control Device***

Attention Dr. _____

Prescription/Letter of Medical necessity" your patient wishes to purchase the ***Pacey Cuff® Bladder Leakage Urethral Control Device*** to manage his **bladder leakage.**

He needs this form for **insurance** purposes as fortunately the product is covered by private insurance plans unlike disposable pads and diapers. Finally, Canadian men can have access to a clinically effective device that is covered by their private insurance, many provincial disability reimbursement programs and federal reimbursement programs for veterans.

What is the ***Pacey Cuff® Bladder Leakage Urethral Control Device?***

- Clinically effective and safe penile compression device for mild to heavy urinary incontinence, dripping and leaking.
- When placed on penis, the padded urethral pressure pad blocks unwanted urine flow.
- Fenestrated Hood allows for normal blood flow.
- Any residual leaks are absorbed by the discrete and reusable ***Incontinence Guard***.
- Can be Comfortably worn even when exercising.
- Keeps skin dry and fights skin irritations associated with adult diapers.
- Velcro strap for custom fit.

Pacey Cuff™ Size Chart - *Guide des tailles Pacey Cuff™*

Length - *Longeur* (cm) \ Circumference - *Circonférence* (cm)	5	6	7	8	9	10	11	12	13
3	SUCD - T 1								
3.5									
4				MUCD-T 2					
4.5								LUCD-T 3	
5 +									

If you have any questions, please contact ***ActivKare*** at tel: 1-855-811-3733. For more detailed **information** on ***Pacey Cuff*** or to see a short product video visit https://activkare.com/product-category/pacey-cuff/

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PACEY CUFF™
URETHRAL CONTROL DEVICE

Instructions:

1) This form is for the ***Pacey Cuff® Bladder Leakage Urethral Control Device.***
2) Please have this form completed by your physician.
3) Physician, please complete all blanks and maintain the original in patient's file.

I have prescribed/recommended the *Pacey Cuff® Bladder Leakage Urethral Control Device* as needed and described herein. It is my expert opinion that it is medically necessary to facilitate management of this patient's urinary function. This recommendation shall also serve as the Certificate of Medical Necessity.

Estimated Length of Need (# months): (99 = Lifetime) _____months
Products to order: ***Pacey Cuff® Urethral Control Device*** ☐ ***Check box***
Incontinence Guard (to absorb any drops). ☐ **Check box**

Physician Information (or nurse continence advisor)

Physician name: _____
Physician Address: _____
Physician Tel #: _____
Physician Fax #: _____ E-mail address: _____
Physician License #: _____Physician signature: _____ Date: _____

Patient Information:

Name: _____Date of Birth:_____
Address:_____
Patient Phone: _____

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