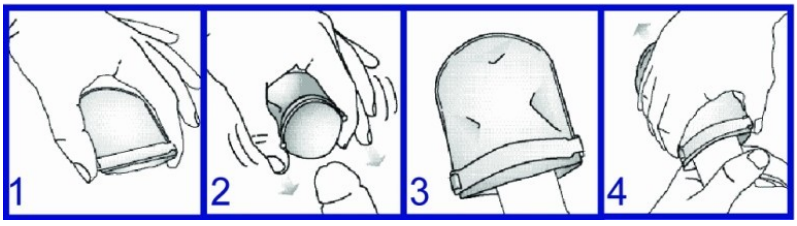
Prescription/Letter of Medical Necessity for ***Urinary Incontinence Management Compression Pouch***

"Prescription/Letter of Medical necessity" your patient wishes to purchase the ***ActiCuf® Urinary Incontinence Management Compression Pouch*** to manage his **bladder leakage.**

He needs this form for **insurance** purposes as the product is covered by private insurance plans unlike all the disposable pads and diapers. 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 and first nations.

What is the ***ActiCuf® Urinary Incontinence Management Compression Pouch?***

- Clinically effective and safe penile compression device for mild urinary incontinence, dripping and leaking.
- When placed on penis, the padded closure gently presses down on the urethra to control urine flow and any leakage is absorbed by absorbent pouch.
- For moderate to serious stress and urge urinary incontinence.
- One ***ActiCuf®*** can be worn all day even when exercising.
- Keeps skin dry and fights skin irritations associated with adult diapers.
- Discrete - small enough to fit in one's pocket.



If you have any questions, please contact ***ActivKare*** at tel: 1-855-811-3733.
For more detailed **information** on ***ActiCuf®*** https://activkare.com/product-category/acticuf/

PRESCRIPTION/LETTER OF MEDICAL NECESSITY

Urinary Incontinence Management Compression Pouch

Instructions:

1) This form is for the ***ActiCuf® Urinary Incontinence Management Compression Pouch.***
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 *ActiCuf® Urinary Incontinence Management Compression Pouch* 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: *ActiCuf® UI Management Compression Pouch* ☐ ***Check box***
Quantity to order per month: *10x1 pack* ☐ ***10x5 pack*** ☐ ***10x10 pack*** ☐

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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