passio™
Disposable Collection Kit

ATTENTION

1. Complete enclosed patient information and prescription forms.
2. These forms must be filled out completely before Drainage Kits can be shipped.
3. Fax forms and copies of insurance cards to Bearpac Medical, LLC Attn: Passio RX Specialist. Fax to: 855-491-4640
4. Place order.
   Patients and healthcare providers may order supplies by calling Bearpac Medical at 833-232-7722.
5. Preserve original order or mail completed forms to:
   Bearpac Medical, LLC
   26 St. James Ave.
   Somerville, MA 02144

BEARPAC MEDICAL

Bearpac Medical, LLC
1-833-BEARPAC
(1-833-232-7722)

bearpac.com

Patient Insurance Information for Passio Disposable Collection Kit

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Patient Information: Complete the following section or attach the patient's face sheet

Patient Name: Last _____ First _____ M.I _____

Patient Phone: ( ) _____

Alternate Contact Name: _____ Alternate Contact Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance Information: Complete the following section

Primary Insurance: _____ Phone: _____

Policyholder: _____ ID #: _____

Employer or Group Name: _____ Group #: _____

Secondary Insurance: _____ Phone: _____

Policyholder: _____ ID #: _____ Group # _____

Hospital Information: Complete the following section

Hospital Name: _____

Date of catheter placement: _____ Discharge date: _____

Name of Passio contact at physicians office: _____

Name of Referring Physician: _____ Phone: _____

Patient Care Information: Complete the following section

Patient is being discharged to: ☐ Home with nursing care (VNA) ☐ Hospice ☐ Skilled nursing facility

Name of provider _____ Care start date: _____

Provider contact name: _____ Phone: _____

Number of Passio Disposable Collection Kits patient is discharged with: _____

☐ Send confirmation that the prescription was received.

Contact me via ☐ Phone: or ☐ E-Mail:

Preserve original order or mail to:
Bearpac Medical, LLC
26 St. James Ave.
Somerville, MA 02144

<< Please fax completed forms to: 855-491-4640 >>

Note:
This prescription or the information contained herein may be shared with or reported to Bearpac Medical, LLC, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients using the Passio Drainage System. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with Bearpac Medical, please call 833-232-7722 and a product specialist will assist with this request and ensure that the Information is not shared.

Passio is a trademark of Bearpac Medical, LLC

Questions? Call Bearpac Medical toll free 24/7: 1-833-BEARPAC (1-833-232-7722)

BEARPAC MEDICAL

Detailed Written Order
Passio Disposable Collection Kit

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Section 1: Complete the following section

Patient Name: Last _____ First _____ M.I _____

Patient Phone: ( ) _____ Date of Birth _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Physician Name _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Location of Service: Home

Section 2: Complete the following section

Primary Diagnosis - Location of Fluid Accumulation (required):

Check appropriate Diagnosis (ICD-9):

☐ 511.9 Unspecified Pleural Effusion ☐ 511.81 Malignant Pleural Effusion Other: _____

☐ 789.51 Malignant Ascites ☐ 789.59 Other Ascites Other: _____

Secondary Diagnosis - Condition Causing Drainage Treatment (required)

Ex.: Diagnosis (ICD-9) 197.0 Lung Cancer, 174.9 Breast Cancer, 183.0 _____ _____

Length of need in months (or write lifetime) _____

Number of kits required:

☐ Once per day (90 Disposable Collection Kits in 90 days)

☐ Every other day (45 Disposable Collection Kits in 90 days)

☐ Other _____

Note: Each box contains 10 Passio Disposable Collection Kits. Each individual kit contains: pump head with collection bag, and 1 Redressing Kit containing: 1 pair latex free gloves, 3 ea. alcohol prep pads, 1 ea. catheter valve cap, 4 ea. 4" x 4" gauze pads, 2 ea. split gauze pads, 1 ea. adhesive dressing, 1 ea. removable blue slide clamp, 1 ea. skin prep wipe

Section 3: To be completed by physician

I certify that I am the physician identified on this form. I have reviewed all sections of the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and Physician notes and other supporting documentation will be provided to Bearpac Medical upon request. I understand any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical records.

Prescriber's Signature _____ (Signature Stamps and Date Stamps Are Not Acceptable)

Date _____ NPI #: _____ UPIN (if applicable: _____

<< Please fax completed forms to: 855-491-4640 >>

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