Keystone First
Community HealthChoices

J&B Medical Supply

50496 W. Pontiac Trail
Wixom, MI 48393
Phone: 1-866-674-5850
Fax: 1-800-737-0012

Diaper and Incontinence Supply Prescription

Date prescribed (MM/DD/YYYY):

Patient name:	Date of birth (MM/DD/YYYY):
Address:	Phone:
Insurance name:	ID number:

Please check off all supplies required.

	Products available for eligible recipients	Quantity requested per day
	Diapers	
	Gloves	
	Liners	
	Pull-ons	
	Undergarments	
	Underpads (blue pads)	
	Washable incontinence pants	

Diagnosis required

Primary condition causing incontinence:

_____

Type of incontinence. Please check **all** that apply to your patient.

☐ Urinary (78830) ☐ Fecal (7876) ☐ Female stress incontinence (6256) ☐ Male stress incontinence (78832)

☐ Other: _____

Requested number of refills: ☐ One year ☐ Other: _____ months

Physician name:	
Degree:	License:
Address:	
Phone:	Fax:

Physician signature: _____