

New Mexico Medicaid Utilization Review

P.O. Box 27950 Albuquerque, NM 87125-7950

Medical Justification for Diapers

Date: _____

Recipient: _____

Medicaid #: _____

Circle One

- | | | |
|--------------------------------------------------------------------------------------------------------------|---|---|
| 1. Is recipient incontinent on a daily basis? | Y | N |
| 2. Is recipient bowel/bladder trainable at this time? | Y | N |
| 3. Is recipient appropriate for further medical, urologic, or surgical intervention? | Y | N |
| 4. Does incontinence produce significant soiling that requires an immediate change of clothes or bedding? | Y | N |
| 5. Could recipient's incontinence be successfully managed with a bedside commode or other assistive devices? | Y | N |

M.D. Signature: _____