CMN Order

FAX: 866-217-9998 ◆ Phone: 1-866-217-9900

"You be the clinician...we'll be the supplier."

Patient Name: ______________________ Date: ______________

Name of Clinic: ______________ City: ______________ Phone: ______________

Name of Nursing Home: ______________ City: ______________ Phone: ______________

In order for Advanced Tissue to process your patient's order, we need the following documentation faxed:
◆ copy of the **PATIENT FACE SHEET** ◆ signed **(AOB)** (at Bottom) ◆ **ORDER SIGNED BY PHYSICIAN**

OTHER PRODUCTS & NOTES

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DRESSINGS	REQUIRED DRAINAGE	WOUND 1	WOUND 2	WOUND 3	WOUND 4
Collagen w/Silver	Low/Heavy				
Collagen #1	Low/Heavy				
Collagen #2	Low/Heavy				
Foam w/ Silver	Mod/Heavy				
Foam	Mod/Heavy				
Calcium Alginate w/ Silver	Mod/Heavy				
Calcium Alginate	Mod/Heavy				
Hydrocolloid #1	Low/Mod				
Hydrocolloid w/ Adhesive	Low/Mod				
Theragauze	No/Low				
Hydrogel Gauze	No/Low				
Non-Adhering Misc.	ANY				
Wrap Dressing #1	ANY				
Gauze Sheet	ANY				
FREQUENCY OF CHANGE					
DESCRIPTION					
SIZE & DEPTH (in cm's)					
LOCATION					
Partial(PT)Full(FT)Thickness					
Drainage (Min. Mod. Heavy)					

Is this patient currently in a **Nursing Home?** ☐ **Yes** ☐ **No**

Duration: 90 Days (Unless Specified)				

Patient Needs Saline? YES NO

Is this patient currently being seen by **Home Health?**
☐ **Yes** ☐ **No**

Have wounds ever been debrided?
☐ **Yes** ☐ **No**

Physician's Name: ______________________ Fax: ______________ Phone: ______________

Signature: ______________________ Date: __________ UPIN: __________ NPI: __________

City: ______________________ State: ______________

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to CDT, Inc. (Advanced Tissue) for any supplies or services furnished to me by Advanced Tissue. **I am responsible for any balance due that is not covered by my insurance.** I understand any product received in my home,opened or unopened, cannot be returned. **I authorize any holder of medical information about me to release to Advanced Tissue any information needed to determine benefits payable for these supplies or services.** Further, I authorize **Advanced Tissue** to forward my medical records to the medical professionals in my care and/or make copies of said records.

Please Print

Patient's Name: ______________________ Date of Birth: __________ Social Security No.: ______________

Address: ______________________ Phone: ______________

Patient's Signature: ______________ Authorized Signature: ______________ Date: __________

Name of Authorized Representative: ______________________
(If patient is unable to sign)