

Acc't Name _____

Acc't Tel # (_____) _____

Patient

Re-order Face Sheet Attached

Order Date _____ of _____

Name (L) _____ (F) _____

Ordered By _____

Address _____ Apt # _____

Male Female D.O.B. _____

City _____ St _____ Zip _____

Tel # (_____) _____

Medicare # _____ Medicaid # _____ SSN # _____

Other Ins _____ Policy # _____ Gp # _____

Ins Tel # (_____) _____ Is the patient being seen by a home health agency? Yes No

Diabetes? Yes No Account Fax _____ Fax Confirmation

Physician

(L) _____ (F) _____ Tel # (_____) _____

NPI # _____

 Signature X _____ Date _____

Duration of Need 1 2 3 _____ (mths)

Wound

	Location	Type or ICD.9 code	Dimensions (cm's)			Drainage ✓				Thickness ✓		Debridement
			Length	Width	Depth	Dry	Lt	Mod	Hvy	Part	Full	or Surgery Date
1)												
2)												
3)												

Dressings 

Days Supply: 15 30

Call your local Byram Account Manager at 1-877-902-8726 for information on TheraGauze Starter Kits

Wound #1

Medicare Guidelines: Full Thickness, Dry to Light Drainage Wounds; Up-to 30/month

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) QD Q2D Q3D
Conforming Bandage Sterile 2" 3" Other Secondary: _____
Size

Wound #2

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) QD Q2D Q3D
Conforming Bandage Sterile 2" 3" Other Secondary: _____
Size

Wound #3

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) QD Q2D Q3D
Conforming Bandage Sterile 2" 3" Other Secondary: _____
Size

Tape

Paper Cloth 2" 3" Other Supplies: _____

Patient Authorization of Release of Information and Assignment of Benefits - My signature on the line below authorizes any of the following. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the Social Security Act) and/or any other Medical Insurance is correct. I authorize the release to Byram Healthcare any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Byram Healthcare on assigned claims. I authorize Byram Healthcare to submit claims to Medicare and/or any other Medical Insurance carrier. I agree to assume responsibility for any balances for supplies furnished to me by Byram Healthcare not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance and non-covered items. I authorize that photo copies shall be valid as originals.

 Patient Signature (Initial order only) X _____ Date _____