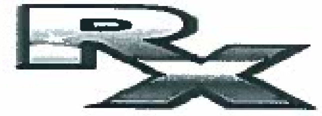

Wound Care Supplies

Rep Name: Phone (866) 710-7679 Fax (800) 218-7670

Date of Service:

Patient Name: ______________________ Date of Birth: ________/________/ ________

Shipping Address: ______________________ Phone Number: ______________________

______________________ Primary Insurance: ______________________

Social Security Number: Secondary Insurance:

Patient's Medical Release and Signature

I hereby acknowledge that I can choose to obtain wound supplies by alternate means. My signature below signifies my selection of Direct Medical Incorporated for delivery of the wound care products in this order. I hereby authorize payment of medical benefits directly to Direct Medical Incorporated. I further authorize the release of any medical information necessary to determine the extent of third party coverage and for processing an insurance claim on my behalf. If my insurance does not pay, Direct Medical Incorporated I am responsible for the outstanding balance. If my insurance does not honor this assignment, I need to forward any payment which I receive as a result of services provided by Direct Medical Incorporated

Patient Signature: **Date:**

Starter Kit Given? YES NO Patient Location: HOME NH

Cleaning Kit Needed? YES NO Is Patient on Home Health? YES NO

Wound #1 Location:______________________ ICD9 Code ________ L______x W______x D______

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Wound #2 Location:______________________ ICD9 Code ________ L______x W______x D______

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Wound #3 Location:______________________ ICD9 Code ________ L______x W______x D______

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Primary Dressing	**Wound Number**		
None to Small			
☐ TheraGauze	1	2	3
☐ Amorphous Hydrogel	1	2	3
☐ Silver Hydrogel *(sheet or gel)*	1	2	3
☐ Gauze Pad *(4x4 or 2x2)*	1	2	3
Any Drainage			
☐ Medfil Particles	1	2	3
☐ Prisma	1	2	3
☐ Promogran	1	2	3
☐ Other Collagen	1	2	3
Moderate to Heavy			
☐ Calcium Alginate	1	2	3
☐ Calcium Alginate Rope	1	2	3
☐ Silvercel *(rope or sheet)*	1	2	3
☐ Maxorb AG *(rope or sheet)*	1	2	3

Other______________________

Secondary Dressing	**Wound Number**		
Any Drainage			
☐ Kling *(3" or 4")*	1	2	3
☐ Kerlix *(Plain or AMD)*	1	2	3
☐ Paper tape *(1" or 2")*	1	2	3
☐ Transparent tape	1	2	3
☐ Gauze Pad *(4x4 or 2x2)*	1	2	3
☐ Bordered Gauze	1	2	3
☐ Coban (1 per week)	1	2	3
☐ ACE Wrap (1 per week)	1	2	3
Moderate to Heavy			
☐ Foam (bordered)	1	2	3
☐ Mepilex Transfer	1	2	3
☐ Foam (non-bordered)	1	2	3
☐ Hydrofera Blue	1	2	3
☐ ABD Pads	1	2	3

Other______________________

NOTES: ______________________

"I certify that the above mentioned product(s) is/are medically necessary for this patient. This form and any statement on my letterhead attached here to has been completed and/or reviewed by me. The foregoing information is true, accurate, and complete."

Physician Signature: ______________________ Date: ____________

Provider Name: ______________________ Phone: ________ Fax: ____________

Provider Address: ______________________ NPI: ____________