STERLING MEDICAL SERVICES
PH - 888.202.5700 • FX - 888.718.5075

Theragauze – Quick Start Order Form

Date Of Order:_____ **Ordered By:**_____

Patient's Name:_____ **Phone#:(**_____**)**_____

Address:_____**City:**_____ **State:**_____ **Zip:** _____

Ship To (if different than above): _____**City:**_____ **State:**_____ **Zip:** _____

Date Of Birth: _____ ☐ **Male** ☐ **Female** †**Known Latex Allergy** ☐ **Yes** ☐ **No**

Primary Insurance : _____**Policy #:** _____**Group#:** _____

Insurance Phone#: _____**Policy Holder:** _____**DOB:** _____

Secondary Insurance: _____**Policy #:** _____**Group#:** _____

Insurance Phone#: _____**Policy Holder:** _____**DOB:** _____

Physician's Name:_____ **NPI:**_____**Phone:(**____**)**_____**Fax:(**____**)**_____

Payment Type (if other than insurance - circle one) MC Visa Disc. Pre-Pay CC #: _____ **Expiration:** _____

Wound Care

Wound #___	**Type:**	**Location:** **DX:** _____ *Diagnosis Must Be Reason For The Supplies*	**Size:** L x Wx D(cm)	**Drainage:** N S M H VH	**Stage:** 1 2P 3F 4F
Primary Dressing:			QD BID TID 3xwk Q____	Qty to be shipped:	
Secondary Dressing:			QD BID TID 3xwk Q____	Qty to be shipped:	
Other Product:			QD BID TID 3xwk Q____	Qty to be shipped:	
Other Product:			QD BID TID 3xwk Q____	Qty to be shipped:	

Description	Circle Size	Order (Pcs)	Description	Circle Size	Order (Pcs
Theragauze Dressing	2"X2"				
Theragauze Dressing	4.125"X4.125"				

Physician Acknowledgment
I certify that this order is reasonable and medically necessary and is not merely convenience items. This document may serve as a confirmation of a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.

Physician's Signature X_____ **Date**_____

Patient Authorization of Release of Information and Assignment of Benefits –
In order for Sterling to bill Medicare and/or other insurance for your medical supplies, please complete, sign and return this form today. You will not be able to place future orders until we receive this form. 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 Sterling Medical Services of any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Sterling Medical Services on assigned claims. I authorize Sterling Medical Services 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 Sterling Medical Services not approved by my insurance policy. This includes but is not limited to deductibles, coinsurances and non-covered items. I authorize that photo copies shall be valid as originals.

Patient/Customer Signature X_____ **Date**_____

The above listing is just a sample of the products we offer, please call us for items not on this list.

†*Sterling Medical relies solely on manufacturer information in determining whether or not a product contains latex. Sterling Medical disclaims all responsibility for any liabilities, claims, losses, lawsuits, judgments, damages and expenses resulting from nonexistent or incorrect manufacturer information. In addition, Sterling Medical disclaims all responsibility for any liabilities, claims, losses, lawsuits, judgments, damages and expenses resulting from unknown or unreported latex allergies. S:\User\Client Services\Mfg_DME_Dr Company Program\J&J Quickstart\J&J Quickstart 022608 Revised 08/14/08*

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