



Wound Care Supplies

Phone (866) 710-7679

Fax (800) 218-7670

Date of Service: _____

Patient Name: _____	Date of Birth: ____/____/____
Shipping Address: _____	Phone Number: _____
Social Security Number: _____	Primary Insurance: _____
	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, INC. 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. **I acknowledge that I am not receiving or having a "home health nurse" treat me for any condition at home. I agree that if a "home health nurse" starts to treat me for any condition I will notify Direct Medical, INC at immediately.**

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	Secondary Dressing	Wound Number
None to Small		Any Drainage	
<input type="checkbox"/> Hydrogel (Sheet or Gauze)	1 2 3	<input type="checkbox"/> Kling (3" or 4")	1 2 3
<input type="checkbox"/> Amorphous Hydrogel	1 2 3	<input type="checkbox"/> Kerlix (Plain or AMD)	1 2 3
<input type="checkbox"/> Amorphous Silver Hydrogel	1 2 3	<input type="checkbox"/> Paper tape (1" or 2")	1 2 3
<input type="checkbox"/> Gauze Pad (4x4 or 2x2)	1 2 3	<input type="checkbox"/> OmniFix (2" or 4")	1 2 3
Any Drainage		<input type="checkbox"/> Gauze Pad (4x4 or 2x2)	1 2 3
<input type="checkbox"/> Stimulen Powder *	1 2 3	<input type="checkbox"/> Bordered Gauze	1 2 3
<input type="checkbox"/> Prisma	1 2 3	<input type="checkbox"/> Coban (1 per week)	1 2 3
<input type="checkbox"/> Promogran	1 2 3	<input type="checkbox"/> ACE Wrap (1 per week)	1 2 3
<input type="checkbox"/> Other Collagen	1 2 3	Moderate to Heavy	
Moderate to Heavy		<input type="checkbox"/> Foam (bordered)	1 2 3
<input type="checkbox"/> Calcium Alginate	1 2 3	<input type="checkbox"/> Mepilex Transfer	1 2 3
<input type="checkbox"/> Calcium Alginate Rope	1 2 3	<input type="checkbox"/> Foam (non-bordered)	1 2 3
<input type="checkbox"/> Silvercel (rope or sheet)	1 2 3	<input type="checkbox"/> MutliPad (2" or 4")	1 2 3
<input type="checkbox"/> Maxorb AG (rope or sheet)	1 2 3	<input type="checkbox"/> ABD Pads	1 2 3

*Can be used in combination with any Primary

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: _____