Wound Care Supplies

In order to process your patient's order please include:
1) Patient demographics (insurance, shipping address, etc.)
2) Wound assessment including ICD-10 Codes

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 wound care products. 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 supplies provided by Direct Medical Incorporated. **I acknowledge that I am not receiving or having a home health nurse or therapist treat me for any condition at home. I agree that if a home health nurse or therapist starts to treat me for any condition I will notify Direct Medical Incorporated 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 #__ Location:______________________ **ICD-10 Codes** __________ __________ L______x W_____x D______
Drainage: None Small Moderate Heavy — *Debridement: Sharp Enzymatic Mechanical Autolytic Pst Srg*
Duration of Treatment: 15 days 30 days — *Frequency of Change: Daily Every other day Every 3rd day Weekly*

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Primary Dressing	Wound Number		
Any Drainage			
☐ Xeroform /vas gauze/ Adaptic	1	2	3
None to Small			
☐ Cool Magic Hydrogel Sheet	1	2	3
☐ *Hydrogel Tube *Plain or Silver*	1	2	3
Small to Moderate Drainage			
☐ Prisma/ Promogran	1	2	3
☐ Endoform	1	2	3
☐ Fibracol *sheet or rope*	1	2	3
☐ Collagen Powder *	1	2	3
Moderate to Heavy			
☐ Eclypse *Silicone or Non-Silicone*	1	2	3
☐ Kerramax Care Gentle Border	1	2	3
☐ Calcium Alginate *Rope or Sheet*	1	2	3
☐ Silver Alginate R*ope or Sheet*	1	2	3
☐ Drawtex / Enluxtra	1	2	3

Secondary Dressing	Wound Number		
Any Drainage			
☐ Kling 2", *3", 4" or 6"*	1	2	3
☐ Kerlix	1	2	3
☐ Paper tape *1" or 2"*	1	2	3
☐ Medipore tape *2" or 3"*	1	2	3
☐ Gauze Pad *4x4 or 2x2*	1	2	3
☐ Bordered Gauze	1	2	3
☐ Co-Lastic 3" or 4"	1	2	3
☐ Elastic Wrap (1 per week)	1	2	3
Moderate to Heavy			
☐ Polymem Max (12/month)	1	2	3
☐ Polymem Max AG (12/month)	1	2	3
☐ Silicone Foam Bordered (12/month)	1	2	3
☐ SIlicone Foam non-Bordered (12/mo)	1	2	3
☐ ABD Pads / Sofsorb / Xtrasorb	1	2	3
☐ Hydrofera Blue *Classic/Ready/Transfer*	1	2	3

*Can be used in combination with any Primary $\geq$ 0.3 depth needed

Notes:

rev 10/23/2019

Compressions Wraps

☐ Circaid Juxta-Lite
☐ Circaid Juxta-Lite HD
☐ Juzo Compression Calf Wrap
☐ Ready Wraps

	Left	Right
Ankle		
Calf		
Length **		

** measure from back of knee to bottom of heel

Compressions Stockings

☐ Carolon Multilayer compression (Black / Beige)
☐ Jobst Vairox Stocking (open toe with Zipper Beige only)
☐ Mediven Dual Layer (Beige only)
☐ ______________________

(All stockings are knee highe and 30 to 40 mmHg)

"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." To my knowledge this patient is not under the care of home health at this time.

Physician Signature: ______________________
Provider Name: ______________________ Phone: Fax:
Provider Address: ______________________ NPI: