direct medical INCORPORATED

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 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 #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			
☐ Hydrogel *(Sheet or Gauze)*	1	2	3
☐ Hydrogel Tube *(plain or AG)	1	2	3
Any Drainage			
☐ Adaptic / Vas gauze / Xeroform	1	2	3
☐ BioPad	1	2	3
☐ Medihoney gel *	1	2	3
☐ Collagen Powder *	1	2	3
☐ Prisma or Promogran	1	2	3
☐ Endoform (fen/nonfen)	1	2	3
Moderate to Heavy			
☐ Calcium Alginate (rope or sheet)	1	2	3
☐ MediHoney Alginate	1	2	3
☐ Sorbion Sachet S	1	2	3
☐ Silver Alginate (rope or sheet)	1	2	3
(circle one) Restore (Hollister) - Silvercel N/A - Algicell AG			

Secondary Dressing	Wound Number		
Any Drainage			
☐ Kling *(3" or 4")*	1	2	3
☐ Kerlix	1	2	3
☐ Paper tape *(1" or 2")*	1	2	3
☐ OmniFix *(2" or 4")*	1	2	3
☐ Gauze Pad *(4x4 or 2x2)*	1	2	3
☐ Bordered Gauze	1	2	3
☐ Co-Lastic (1 per week)	1	2	3
☐ Elastic Wrap (1 per week)	1	2	3
Moderate to Heavy			
☐ Foam-bordered (12/month)	1	2	3
☐ Foam non-bordered (12/month)	1	2	3
☐ Multipad	1	2	3
☐ Xtrasorb	1	2	3
☐ ABD Pads	1	2	3
☐ Hydrofera Blue (12/month)	1	2	3

*Can be used in combination with any Primary ≥ 0.3 depth needed

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." 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: