℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
SURGICAL DRESSING & BANDAGES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by:_____

Surgical Dressing & Bandage:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Type of Bandage:

ALGINATE OR OTHER FIBER GELLING DRESSING (A6196-A6199):
- ☐ _____QTY_____
- ☐ _____QTY_____

COMPOSITE DRESSING (A6203-A6205):
- ☐ _____QTY_____
- ☐ _____QTY_____

CONTACT LAYER (A6206-A6208):
- ☐ _____QTY_____
- ☐ _____QTY_____

FOAM DRESSING (A6209-A6215):
- ☐ _____QTY_____
- ☐ _____QTY_____

GAUZE, NON-IMPREGNATED (A6216-A6221, A6402-A6404, A6407):
- ☐ _____QTY_____
- ☐ _____QTY_____

GAUZE, IMPREGNATED, WITH OTHER THAN WATER, NORMAL SALINE, HYDROGEL, OR ZINC PASTE (A6222-A6224, A6266):
- ☐ _____QTY_____
- ☐ _____QTY_____

GAUZE, IMPREGNATED, WATER OR NORMAL SALINE (A6228-A6230):
- ☐ _____QTY_____
- ☐ _____QTY_____

HYDROCOLLOID DRESSING (A6234-A6241):
- ☐ _____QTY_____
- ☐ _____QTY_____

HYDROGEL DRESSING (A6231-A6233, A6242-A6248):
- ☐ _____QTY_____
- ☐ _____QTY_____

SPECIALTY ABSORPTIVE DRESSING (A6251-A6256):
- ☐ _____QTY_____
- ☐ _____QTY_____

TRANSPARENT FILM (A6257-A6259):
- ☐ _____QTY_____
- ☐ _____QTY_____

TAPE (A4450, A4452):
- ☐ _____QTY_____
- ☐ _____QTY_____

Special Instructions: _____

_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Number of Wounds_____
2. Location of the Wounds_____
3. Does the patient need to change the dressing more than one (1) time per day?
   ☐ Y ☐ N
   Specific Frequency:_____
4. Does the patient have a co-morbidity (i.e. Diabetes) that may affect the wound from healing and/or extend the healing time?
   ☐ Y ☐ N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

_____

Provider's Signature Date

_____

Provider's Name

NPI: _____ Telephone: _____