


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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  915 30th Avenue Suite 106 Fairbanks, AK 99701 Phone: _____ (907) 458-8912 NSC#: _____ Fax: (907) 458-8914 1267160002	Patient Name, Address, Telephone & HIC#: () - HIC#: _____ Patient DOB: / / Sex: (M/F)
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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:

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: _____