


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
SURGICAL DRESSING & BANDAGES**

Date of Last Provider Visit \_\_\_\_\_

<p><b>Supplier Name, Address, Telephone &amp; NSC#:</b></p>  <p><b>901 N Leatherleaf Loop Suite 104 Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003</b></p>	<p><b>Patient Name, Address, Telephone &amp; HIC#:</b></p> <p>(       )       -       HIC#:       .</p> <p><b>Patient DOB:</b>       /       /       <b>Sex:</b>       (M/F)</p>
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We have been asked to provide the following equipment to the patient named above. 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.

**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: \_\_\_\_\_