℞ 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 **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

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: _____