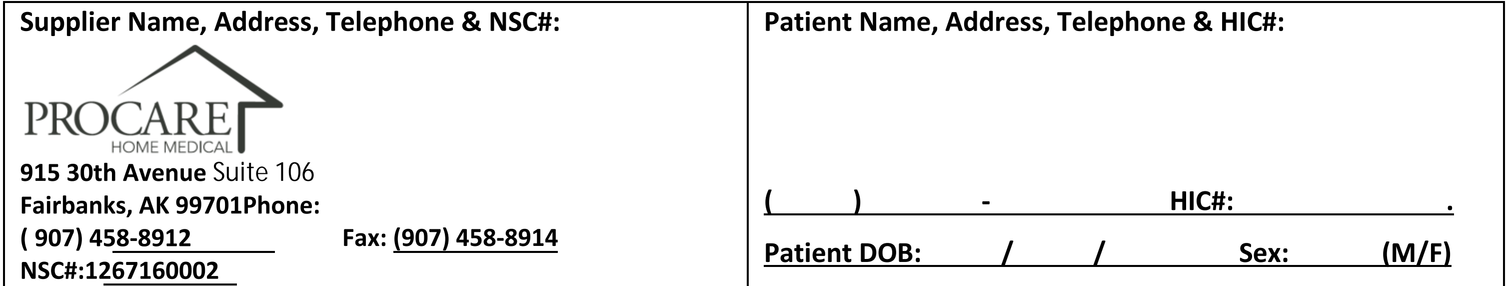
℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
SURGICAL DRESSING & BANDAGES

Date of Last Provider Visit__________________



Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** Suite 106 **Fairbanks, AK 99701Phone:** **(907) 458-8912** **Fax: (907) 458-8914** **NSC#:1267160002**	**( ) - 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:

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: ______________________________

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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: _______________

Updated 07-23-20