

WOUND CARE PHYSICIAN ORDER

Fill out this form and include the patient's demographics and insurance information.



P: 888.771.9229 | F: 866.680.5574 | strivemedical.com

Patient Name: _____ Order Start Date: ____/____/____

Patient Phone: _____ Patient DOB: ____/____/____

Facility: _____ Phone: _____

City: _____ State: _____ Fax: _____

Wound Care Dressings Needed

Patient is aware of this order Yes No

| | Wound 1 | Wound 2 | Wound 3 |
|--|--|--|--|
| ICD-10 Codes (Diagnosis) | | | |
| Wound Size (LxWxD) | _____ x _____ x _____ (cm) | _____ x _____ x _____ (cm) | _____ x _____ x _____ (cm) |
| Wound Location | _____ <input type="checkbox"/> L <input type="checkbox"/> R | _____ <input type="checkbox"/> L <input type="checkbox"/> R | _____ <input type="checkbox"/> L <input type="checkbox"/> R |
| Thickness | <input type="checkbox"/> Full <input type="checkbox"/> Partial | <input type="checkbox"/> Full <input type="checkbox"/> Partial | <input type="checkbox"/> Full <input type="checkbox"/> Partial |
| Stage (Pressure Ulcers) | <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 | <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 |
| Exudate | <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Heavy | <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Heavy | <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Heavy |
| Debridement - required by Medicare (unless surgical wound) | <input type="checkbox"/> Yes, Date _____ <input type="checkbox"/> No | <input type="checkbox"/> Yes, Date _____ <input type="checkbox"/> No | <input type="checkbox"/> Yes, Date _____ <input type="checkbox"/> No |

| *Items require FULL thickness for Medicare insurance coverage | Frequency of Change Wound 1 | Frequency of Change Wound 2 | Frequency of Change Wound 3 |
|---|-----------------------------|-----------------------------|-----------------------------|
| *Alginate/Gelling Fiber <input type="checkbox"/> Silver | | | |
| *Collagen <input type="checkbox"/> Silver | | | |
| *Foam – Bordered <input type="checkbox"/> Silver | | | |
| *Foam – Non-bordered <input type="checkbox"/> Silver | | | |
| *Hydrogel Filler <input type="checkbox"/> Silver | | | |
| *Hydrogel Sheet <input type="checkbox"/> Silver | | | |
| *Specialty Absorptive (ABD) | | | |
| Composite Dressing | | | |
| Contact Layer | | | |
| Gauze | | | |
| Gauze – Bordered | | | |
| Gauze – Impregnated | | | |
| Gauze – Roll | | | |
| Hydrocolloid Dressing | | | |
| Transparent Film | | | |
| Other: | | | |

Compression

Insurance Coverage

Does the patient have a debrided open venous stasis ulcer? Y N

Does the patient have a current Lymphedema diagnosis? Y N

Medicare only covers below products if a venous stasis ulcer is present or with a Lymphedema diagnosis.

Products

Please refer to the back of this form for Medicare guidelines for quantity and frequency of items.

Compression Garment

Jobst UlcerCare L R

FarrowWrap L R

Other: _____ L R

Multilayer Compression Bandage Systems

TwoPress2 L R

ThreePress L R

FourPress L R

Compri2 L R

Comprifore L R

Other: _____ L R

Measurements (cm)

Calf (Circumference) _____ L _____ R

Ankle (Circumference) _____ L _____ R

Length (Back of knee to floor) _____ L _____ R

Compression Level

30-40 mmHg L R

40-50 mmHg L R

Does the patient currently have any of the requested products at home?

Yes No

If Yes, list the remaining qty of each product in Notes section.

Notes

Provider Info

Physician Name: _____ Date: ____/____/____

Physician NPI: _____ Signature: _____

This Rx is valid for 90 days. Any edits need to be initialed and dated by the physician.

Medicare Checklist for WOUND CARE SUPPLIES

For any questions or assistance feel free to contact a Strive Medical Wound Care Specialist at 888.771.9229.



FOR SURGICAL DRESSINGS

PATIENT FACE SHEET

- Patient Name
- DOB
- Address/Phone Number
- Insurance Information

DISPENSING ORDER

- Patient Name & DOB
- Products Needed
- NPI
- Doctor Signature & Date
- Frequency of Change
**If the frequency of change is more than QD, please provide reason for the frequency.*

WOUND ASSESSMENT/ PLAN OF CARE

- Wound Location (*L-Left; R-Right*)
- Type of Wound (*Arterial, Diabetic, Pressure, Surgical, Trauma (includes burns), and Venous*)
- Wound Size (*length x width x height*)
- Drainage (*minimum, moderate or heavy*)
- Stage (*II, III or IV*) **if applicable*
- Thickness (*full or partial*) **if applicable*

FAX ALL DOCUMENTS TO 866.680.5574

- Patient Face Sheet
- Detailed Written Order
- Wound Assessment / Plan of Care

*****Medicare requires a new wound assessment every 30 days*****

Medicare Maximum Allowed per wound/per month

KEY: adh = adhesive, hyd = hydrogel, NS = normal saline, w/out = without, w/ = with

| TYPE OF DRESSING | HCPC/SIZE | QTY |
|--|---------------------------------------|--------------|
| Alginate Dressing, wound cover | A6196 (2x2), A6197 (4x4), A6198 (6x6) | 30 Dressings |
| Alginate Rope, wound filler | A6199 (per 6 inches) | 60 Dressings |
| Collagen Dressing, sterile | A6021 (2x2), A6022 (4x4), A6023 (6x6) | 30 Dressings |
| Collagen Filler, dry form, sterile | A6010 (per gram) | 30 Grams |
| Collagen Filler, gel/paste | A6011 (per gram) | 30 Grams |
| Collagen Dressing, wound filler, sterile | A6024 (per 6 inches) | 60 Dressings |
| Composite Dressing, sterile, w/adh | A6203 (2x2), A6204 (4x4), A6205 (6x6) | 12 Dressings |
| Contact Layer, sterile | A6206 (2x2), A6207 (4x4), A6208 (6x6) | 4 Dressings |
| Foam Dressing, w/out adh border | A6209 (2x2), A6210 (4x4), A6211 (6x6) | 12 Dressings |
| Foam Dressing, w/adh border | A6212 (2x2), A6213 (4x4), A6214 (6x6) | 12 Dressings |
| Non-impregnated & Non-Sterile: | | |
| Gauze w/out adh border | A6216 (2x2), A6217 (4x4), A6218 (6x6) | 30 Dressings |
| Gauze w/adh border | A6219 (2x2), A6220 (4x4), A6221 (6x6) | 30 Dressings |
| Impregnated with other than water, sterile: | | |
| Gauze, NS, or hyd, w/out adh border | A6222 (2x2), A6223 (4x4), A6224 (6x6) | 30 Dressings |
| Gauze, NS, or zinc paste, any width | A6266 (per linear yard) | 150 Yard |
| Impregnated and sterile: | | |
| Gauze, water or NS, w/out adh border | A6228 (2x2), A6229 (4x4), A6230 (6x6) | 30 Dressings |
| Gauze, hyd, for direct wound contact | A6231 (2x2), A6232 (4x4), A6233 (6x6) | 30 Dressings |
| Hydrocolloid Dressing, w/out adh | A6234 (2x2), A6235 (4x4), A6236 (6x6) | 12 Dressings |
| Hydrocolloid Dressing, w/adh border | A6237 (2x2), A6238 (4x4), A6239 (6x6) | 12 Dressings |
| Hydrocolloid Filler, Paste | A6240 (per ounce) | 12 Ounces |
| Hydrocolloid Filler, Dry Form | A6241 (per gram) | 12 Grams |
| Hydrogel Dressing, w/out adh border | A6242 (2x2), A6243 (4x4), A6244 (6x6) | 30 Dressings |
| Hydrogel Dressing, w/any size border | A6245 (2x2), A6246 (4x4), A6247 (6x6) | 12 Dressings |
| Hydrogel Dressing, Filler, gel | A6248 (per fluid ounce) | 3 Ounces |
| ABD Pads: | | |
| Specialty Absorpt. Dressing, w/out adh | A6252 (5x9), A6253 (8x10) | 30 Dressings |
| Specialty Absorpt. Dressing, w/adh | A6255 (5x9), A6256 (8x10) | 15 Dressings |
| Transparent Film, sterile | A6257 (2x2), A6258 (4x4), A6259 (6x6) | 12 Dressings |
| Tube Gauze | A6457 (per yard) | 30 Yards |
| Tape, non-waterproof | A4450 (2 in x 10 in) | 40 Units |
| Tape, waterproof | A4452 (2 in x 10 in) | 40 Units |

Several dressings available with silver (AG)

Medicare Compression Quantity and Frequency:

- Covers 1 compression garment per affected body part every 6 months and 1 multi-layer compression system up to twice weekly with a present venous stasis ulcer
- Covers 3 compression garments per affected body part every 6 months and with a current Lymphedema diagnosis

Medicare Non-Covered Items

- A6025 - A silicone gel sheet used for treatment of keloids
- A6250 - Skin sealants, barriers, protectants, moisturizers, ointments
- A6260 - Wound cleansers or irrigating solutions, topical antiseptics, etc.