CMN Order

Fax: 866-217-9998 ♦ Phone: 866-217-9900

"You be the clinician… we'll be the supplier"

Patient Name: _____ Date: _____

Name of Clinic: _____ City: _____ Phone: _____

Name of Nursing Home: _____ City: _____ Phone: _____

In order for Advanced Tissue to process your patient's order, we need the following documentation faxed:

♦ copy of the **PATIENT FACE SHEET** ♦ signed (**AOB**) (at bottom) ♦ **ORDER SIGNED BY PHYSICIAN**

OTHER PRODUCTS & NOTES	DRESSINGS	DRAINAGE	WOUND 1	WOUND 2	WOUND 3	WOUND 4
	Amerigel Saturated Gauze	No/Low				
	Amerigel Hydrogel 1oz	Any				
	Gauze AMD 2x2	Any				
	Gauze AMD 4x4	Any				
	Bordered Gauze	Any				
	Bordered Foam	Mod/Heavy				
	Non-Bordered Foam	Mod/Heavy				
	Hydrocolloid	Min/Mod				
	Absorbent Dressing	Heavy				
	Kerlix AMD 4"	Any				
	Tape (Paper)	Any				
	Medipore Tape 1" / 2" / 4"	Any				
	Kind Removal Silicone Tape 1"	Any				

FREQUENCY OF CHANGE				
DESCRIPTION				
SIZE & DEPTH (in cm's)				
LOCATION				
Partial(PT) Full(FT) Thickness				
Drainage (Min. Mod. Heavy)				
Is This Patient Currently in a **Nursing Home?** ☐ **Yes** ☐ **No**				
Duration:90 Days (Unless Specified)				

Patient Needs Saline? YES NO

Is this patient currently being seen by **Home Health?**

☐ **Yes** ☐ **No**

Have wounds ever been debrided?

☐ **Yes** ☐ **No**

I certify that I am treating the patient identified on this form and ordering the listed supplies based on my examination/treatment of the patient. I affirm that the ordered supplies are medically reasonable and necessary. I have noted on the form my medical findings regarding the patient's wound(s) and medical supply needs. I am maintaining documentation regarding my medical treatment of the patient and will make it available upon request.

Physician's Name: _____ Fax: _____ Phone: _____

Signature: _____ Date: _____ UPIN: _____ NPI: _____

City: _____ State: _____

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Advanced Tissue for any supplies or services furnished to me by Advanced Tissue. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to Advanced Tissue any information needed to determine benefits payable for these supplies or services. Further, I authorize Advanced Tissue to forward my medical records to the medical professionals in my care and/or make copies of said records.

Please Print

Patient's Name: _____ Date of Birth: _____ Social Security No.: _____

Address: _____ Phone: _____

Patient's Signature: _____ Authorized Signature: _____ Date: _____

Name of Authorized Representative: _____