direct medical
INCORPORATED

Wound Care Supplies

Phone (866) 710-7679 Fax (800) 218-7670

Date of Service:

Patient Name: _____	Date of Birth: _____/_____/_____
Shipping Address: _____	Phone Number: _____
_____	Primary Insurance: _____
Social Security Number:	Secondary Insurance:

Patient's Medical Release and Signature

I hereby acknowledge that I can choose to obtain wound supplies by alternate means. My signature below signifies my selection of Direct Medical Incorporated for delivery of the wound care products in this order. I hereby authorize payment of medical benefits directly to Direct Medical Incorporated. I further authorize the release of any medical information necessary to determine the extent of third party coverage and for processing an insurance claim on my behalf. If my insurance dose not pay, Direct Medica, INC. I am responsible for the outstanding balance. If my insurance does not honor this assignment, I need to forward any payment which I receive as a result of services provided by Direct Medical Incorporated. **I acknowledge that I am not receiving or having a "home health nurse" treat me for any condition at home. I agree that if a " home health nurse" starts to treat me for any condition I will notify Direct Medical, INC at immediatly.**

Patient Signature: **Date:**

Starter Kit Given?	YES	NO	Patient Location:	HOME	NH
Cleaning Kit Needed?	YES	NO	Is Patient on Home Health?	YES	NO

Wound #1 Location:_____ ICD9 Code _____ L_____x W_____x D_____

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Wound #2 Location:_____ ICD9 Code _____ L_____x W_____x D_____

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Wound #3 Location:_____ ICD9 Code _____ L_____x W_____x D_____

Drainage: None Small Moderate Heavy *Debridement: Sharp Enzymatic Mechanical Autolytic*

Duration of Treatment: 15 days 30 days *Frequency of Change: Daily Every other day Every 3rd day Weekly*

Primary Dressing	Wound Number			Secondary Dressing	Wound Number		
None to Small				**Any Drainage**			
☐ AmeriGel® Gauze Dressing *(2x2)*	1	2	3	☐ Kling *(3" or 4")*	1	2	3
☐ Amorphous Hydrogel	1	2	3	☐ Kerlix *(Plain or AMD)*	1	2	3
☐ AmeriGel® Wound Dressing	1	2	3	☐ Paper tape *(1" or 2")*	1	2	3
☐ Gauze Pad (*4x4 or 2x2)*	1	2	3	☐ OmniFix (*2" or 4"*)	1	2	3
Any Drainage				☐ Gauze Pad (*4x4 or 2x2)*	1	2	3
☐ Stimulen Powder *	1	2	3	☐ Bordered Gauze	1	2	3
☐ Prisma	1	2	3	☐ Coban (1 per week)	1	2	3
☐ Promogran	1	2	3	☐ ACE Wrap (1 per week)	1	2	3
☐ Other Collagen	1	2	3	**Moderate to Heavy**			
Moderate to Heavy				☐ Foam (bordered)	1	2	3
☐ Calcium Alginate	1	2	3	☐ Mepilex Transfer	1	2	3
☐ Calcium Alginate Rope	1	2	3	☐ Foam (non-bordered)	1	2	3
☐ Silvercel (*rope or sheet)*	1	2	3	☐ MutliPad *(2" or 4"*)	1	2	3
☐ Maxorb AG (*rope or sheet)*	1	2	3	☐ ABD Pads	1	2	3

*Can be used in conbination with any Primary

Other_____

NOTES: _____

"I certify that the above mentioned product(s) is/are medically necessary for this patient. This form and any statement on my letterhead attached here to has been completed and/or reviewed by me. The foregoing information is true, accurate, and complete."

Physician Signature: _____ Date: _____

Provider Name: _____ Phone: _____ Fax: _____

Provider Address: _____ NPI: _____