

# FILLING OUT THE WOUND CARE RESOURCES ORDER FORM

We recommend that you use this guide to fill out order forms the first few times so we can keep our phone calls to you to a minimum. Our simple one page order form is based on Medicare guidelines that must be followed when distributing dressings. WCR will call you only if there is an order inconsistent with the Medicare guidelines detailed here.

**Patients having Medicare B as their primary insurance and receiving home health care services for any reason may not use this service until they are discharged.**

**OR**

You may call our office at (888) 287-9797, and we'll fill out the order form for you.

## **WOUND INFORMATION CIRCLE CHOICES AND FILL IN BLANKS (required information by all insurance)**

**Wound stage** - Circle II, III or IV if wound is a pressure ulcer; P (partial) or F (full) for other wound types.

**ICD9 Code** – Use diagnosis codes you are using for billing. WCR office will assign codes to nursing home patients.

**Size** – in centimeters (L x W x D) **PLEASE INCLUDE DEPTH MEASUREMENT**

**Location** – specify area as in “L lower leg,” not just “left leg”

**Drainage** – circle min, mod, heavy. Drainage descriptions dictate the products you may order below.

**Is wound debrided?** – answer must be “yes.” Some form of debridement must have occurred at some time during the treatment of the wound but not necessarily the same day dressings are ordered.

**Duration of need** – best to circle **90 (days)** as we will contact you monthly before sending dressings. Any order may be changed or discontinued when our office calls/faxes/emails to confirm need for the next month's order.

**Frequency**– circle qd, qod, or wkly indicating how often dressing should be changed

## **CUSTOMIZED DRESSING ORDERS – Style, Drainage and Units/Mo. columns are only for your information.**

**Style** –Our office will send the largest size possible based on wound size & insurance guidelines.

**Drainage type** –This column indicates **Medicare drainage requirements** for that particular dressing. This drainage description should be consistent with what you have marked above in the “drainage” area.

**Units/mo** – This column indicates **Medicare guidelines** as to how much we can legally provide per month.

**This must match up “frequency”** under wound information. For example, you cannot circle “qd” and request foam since it can only be provided 3 times/wk. If you circle qd you should choose a dressing that is available in a daily dose (30 or 3 oz.): “qod” is circled for those products available in 12 units/mo.

**Greater amounts can be sent if extra documentation is provided to support the need.**

**Wound 1, 2, and 3** – check desired dressings down columns. Dressings may be ordered for up to 9 wounds.

The tiny P and S in each box are for office use only.

## **OTHER PRODUCTS OR SPECIFIC BRANDS**

If you prefer a certain brand or product, please write it in this area. If we cannot provide what you have requested we will notify you ASAP. Substitutions are NOT made without your approval.

## **CAROLON MULTI LAYER COMPRESSION SYSTEM**

Paid for by Medicare and other insurance if patient has an **OPEN VENOUS ULCER**. Patient may receive two under-layers and two over-layers (one box) per month as long as he has a wound.

## **WE MUST HAVE THE FOLLOWING TO FILL AN ORDER: OUR OFFICE CAN HELP YOU GET THIS INFORMATION**

**Patient/Caregiver signature:** this gives us permission to bill his insurance.

**Physician Name:** please write in along with his/her NPI number.

**Physician Signature:** If not in your facility, please provide us the phone number, and we will get the signature

**Our office will be glad to assist you if you prefer that we fill out the order form with you by phone. Orders can also be sent via our online order form at**

**[www.woundcareresources.net](http://www.woundcareresources.net)**

**PLEASE PROVIDE US THE PATIENT'S DEMOGRAPHIC SHEET FOR EACH ORDER**