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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Surgical Dressings / Wound Care Items

Date Ordered: ____/____/_____

Patient's Name: _____ **DOB:** _____/_____/_____

Patient's Address: _____

_____

Insurance ID #: _____

****Coverage Criteria (please check all that apply)****

☐ The surgical dressings are being used for the treatment of a wound caused or treated by a surgical procedure, or…

☐ The surgical dressings are being used after debridement of a wound, or…

☐ Other:_____

****Please complete all of the following that apply:**

Name of Surgical Dressing / WoundCare Ordered	Size of Dressing	Number of Wounds	Total Quantity Per Dressing Change for <u>All Wounds</u>	Frequency of Dressing Change	Expected Duration of Need

Diagnosis/ICD-10 Code:_____ **Length of Need:** _____

Physician Name:_____ **NPI #** _____

Physician's Address:_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____**Date** ____/____/_____

LC