REGENADERM

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Wound notes / Treatment plan required for processing orders

STEP 1

PATIENT INFORMATION:

Name: (First)_____ (Middle Initial) _____ (Last) _____ DOB: _____

Please enter name as it appears on the insurance card

Please attach demographics and insurance or complete all patient information below.

Shipping Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Insurance Name: _____ Secondary Insurance Name: _____

ID Number: _____ Group Number: _____ ID Number: _____ Group Number: _____

Payer's Phone Number: _____ Payer's Phone Number: _____

(Leave blank if same as shipping address)

Billing Address: _____

City: _____ State: _____ Zip: _____

STEP 2

Is the Patient currently being seen by Home Health or Hospice? ☐Yes (Not Applicable) **☐No**

Authorizations: The patient is requesting coordination of care: ☐Yes ☐No (Not Applicable)

The patient has chosen Prism to assist in providing the requested care by either providing product, verifying insurance benefits, billing for services, or coordinating care should direct service not be an option.

STEP 3

WOUND ASSESSMENT: Must also be documented in visit note.

Date of Visit: _____

	WOUND 1	WOUND 2	WOUND 3
Diagnosis Code/ICD-10	_____	_____	_____
Cause	☐*Surgically Created or* ☐ ☐*Stalled**	☐*Surgically Created or* ☐ ☐*Stalled**	☐*Surgically Created or* ☐ ☐*Stalled**
**If stalled, date of debridement required*	☐*YES, Date* _____/_____/_____	☐*YES, Date* _____ /____ _____	☐*YES, Date* _____ /_____ /_____
Location	_____ ☐*Lt* ☐*Rt*	_____ ☐*Lt* ☐*Rt*	_____ ☐ *L*☐*Rt*
Size (cm)	*L* _____*xW* _____ *xD* _____	*L* _____*xW* _____ *xD* _____	*L* _____*xW* _____ *xD* _____
Thickness	☐ *Full* ☐*Partial(N/A)*	☐ *Full* ☐*Partial(N/A)*	☐ *Full* ☐*Partial(N/A)*
Drainage	☐ *Moderate* ☐*Heavy(N/A)*	☐ *Moderate* ☐*Heavy(N/A)*	☐ *Moderate* ☐*Heavy(N/A)*
Duration of Need	☐ *90 days* ☐ _____ *days*	*(Patients will receive a 30-day supply and contacted every 30 days for refills as needed, up to 90 days)*	

(N/A) designated options that are not covered by A6021 reimbursement.

STEP 4

PRODUCT SELECTION & FREQUENCY: Please add checks in sections 1, 2, & 3.

1. PRIMARY DRESSING	WOUND 1	WOUND 2	WOUND 3
VERIS™ Collagen with Manuka Honey	☐*Daily* ☐*Every other day*	☐*Daily* ☐*Every other day*	☐*Daily* ☐*Every other day*

2. SECONDARY DRESSING	WOUND 1	WOUND 2	WOUND 3
Bordered Gauze	☐	☐	☐
Gauze and Tape☐	☐	☐	☐
Telfa Island (Bordered Dressing)	☐	☐	☐
Telfa and Tape☐	☐	☐	☐
Other _____	☐	☐	☐
☐Type of Tape	☐*Brown* ☐*Waterproof* ☐*Sensitive*	☐*Brown* ☐*Waterproof* ☐*Sensitive*	☐ *Brown* ☐ *Waterproof* ☐*Sensitive*

Secondary dressings not listed above may not be covered by insurance, and/or may be allowed only in limited quantities which could affect the quantity of the primary dressing.

3. ADDITIONAL ITEMS

☐*Cleansing Kit (Saline, Gloves, Cotton Tip Applicators, Skin Prep Wipes)*

NOTES:

STEP 5

CLINICIAN & FACILITY INFORMATION:

Facility Name: _____ Facility Fax: _____

Point of Contact: _____ Phone: _____

Clinician Name: _____ Prescriber NPI: _____

Signature: _____ Date: _____