7510 Highway 107
Sherwood, AR 72120-4645
Tel: 479.439.9696 Fax: 479.485.2055
orders@regenadermrx.com
www.regenadermrx.com

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 RegenaDerm to assist in providing the requested care by 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 # _____	**WOUND # _____**	**WOUND # _____**
Diagnosis Code/ICD-10			
Frequency of change			
**If not surgical, Date of debridement*	*Date* ____/____/____	*Date* ____/_/____ ____	*Date* ____/____/____
Location	________ ☐*Lt* ☐*Rt*	________ ☐*Lt* ☐*Rt*	________ ☐*Lt* ☐*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	☐ *Minimal* ☐ *Moderate* ☐ *Heavy*	☐ *Minimal* ☐ *Moderate* ☐ *Heavy*	☐ *Minimal* ☐ *Moderate* ☐ *Heavy*
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 2 & 3.

1. PRIMARY DRESSING

Indicate Primary Dressing for each wound			

2. SECONDARY DRESSING

	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
Type of Tape	☐*Paper* ☐*Other* ________	☐*Paper* ☐*Other* ________	☐ *Paper* ☐ *Other* ________

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

☐*Saline* ☐*Gloves* ☐*Cotton Tip Applicators*

NOTES:

STEP 5

CLINICIAN & FACILITY INFORMATION:

Facility Name: ____________________ Facility Fax: ________________

Point of Contact: ____________________ Phone: ________________

Provider Name:____________________ **Prescriber NPI:**________________

Signature: ____________________ Date: ________________