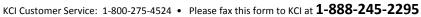


## V.A.C.® Therapy Insurance Authorization Form v.3



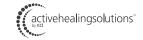


## Patient Information (Important: Please submit demographic and/or insurance sheet)

Patient Name (print) Last:	First			MI:	Patien	t DOB:/
(skip completing patient's home address						
Home Address:						
City: Emergency Contact (if available):	ST:	zip Code:		Phone #: _ Phone #:		
Emergency Contact (if available): Primary Insurance	Policy#	2 <sup>nd</sup> Ir	าร		Policy#	
2 Prescriber Information	on (Complete in f	ull or fax writte	n pres	cription to inclu	ide the	following)
I prescribe KCI V.A.C.® Therapy for the fo Surgically Created Creovide narrative description specifying v	ther			<u> </u>		<u> </u>
I prescribe KCI V.A.C.® Therapy for: and up to 15 V.A.C.® Therapy dressings p Starting Date of V.A.C.® Therapy:/	er wound and up to 10 '	V.A.C.® Therapy canis	sters per	month.		
Goal at the completion of KCI V.A.C.® The	erapy: Assist in gran	ulation tissue format	ion 🔲	Flap Graft I	Delayed Pri	mary closure (tertiary)
Treating prescriber name (print) Last		First:				MI
Address:		City: _			ST:	Zip:
Prescriber Phone:	F	ax:		NPI:		
	Prescriber Only to Com	plete Original Signat	ure Req	uired. No Stamps		
Prescriber Signature:						
been tried or considered and ruled out. I have as the KCI V.A.C.® Therapy Clinical Guidelines. osteomyelitis, non-enteric and unexplored fist (GranuFoam™, Simplace™ and WhiteFoam) for nerves. The Durable Medical Equipment Me each additional month of coverage, a new pre	I also understand the KCI \ ulas, necrotic tissue with e r the V.A.C.® Therapy Syste edicare Administrative Con	'.A.C.® Therapy System schar present, sensitivit em should not be placed tractors (DME MACs) st	contraind ty to silve d directly tate that b	lications: Patients with r (V.A.C. GranuFoam Sil in contact with exposed beyond the first four mo	malignancy i ver® Dressin I blood vessin onths of ther	n the wound, untreated g only). Foam dressing els, anastomotic sites, orga apy, "to justify the need fo
Supplies for Delivery  Supplies for Delivery - Please check  V.A.C.® Simplace™ Dressing  V.A.C.® GranuFoam™ Dressing  V.A.C.® WhiteFoam Dressing  Other Dressing:	Small Small Small	Medium Medium La Large		V.A.C.® (	GranuFoal GranuFoal	m™ Bridge m™ Bridge XG
4 Requestor & Post-Acu			tion			
 Requestor Facility Information (Must	complete in full)					
Requestor's Name	•	Title:		Requestor Phone:		
Facility Name:				Fay#		
Facility Name:  Delivery Location: Home Fa	cility/ RM#·	Other				
Delivery Address:	Cility/ 1(1VI#	City:			State:	7in:
KCI V.A.C.® System will be used in wh						
•						
Post-Acute Clinical Provider administ						
Address: Patient Name:						
PALIENT NAME.		D.U.B.: /	1	completed by:		



## V.A.C.® Therapy Insurance Authorization Form v.3



KCI Customer Service: 1-800-275-4524 • Please fax this form to KCI at **1-888-245-2295** 

Sa Clinical information by wound Type						
1. Was NPWT initiated in an inpatient facility?	Yes No Date Initiated:/					
OR has the patient been on NPWT anytime during the last 60 days?	Yes No Facility Name:					
2. Is the patient's nutritional status compromised?	Yes No Facility City, St:					
If yes, check the action taken:  Protein Supplements  Entera	al/NG Feeding ☐TPN ☐ Vitamin Therapy ☐ Special Diet					
3. Indicate other therapies that have been previously tried and/or failed to	maintain a moist wound environment:					
☐ Saline Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid	Absorptive None Other:					
4. If other therapies were considered and ruled out, what conditions preve	nted you from using other therapies prior to applying V.A.C.® Therapy?:					
☐ Presence of co-morbidities ☐ High risk of infections ☐	Need for accelerated granulation tissue					
Prior history of delayed wound healing	Other, please describe:					
5. Which of the following co-morbidities apply? Diabetes Immobility	Immunocompromised ESRD PVD PAD Obesity Smoking Depression N/A					
6. If above diabetes box checked, is the patient on a comprehensive diabet						
7. Is Osteomyelitis present in Wound? $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	icate the following:					
Antibiotic(list name) IV An	ntibiotics (list name)					
Is the above treatment administered to the patient with the intention to	completely resolve the underlying bone infection?					
	rapy is not used. (Please include/attach any clinical data such as H&P, OP report, and other					
medical documentation supporting treatments tried and describing fac	tors impacting wound healing):					
5b Patients Primary Wound Type						
<u> </u>						
PRESSURE ULCER: ☐Stage III ☐Stage IV.	Please Complete if Applicable					
1. Is the patient being turned/positioned?	Yes No Is wound a direct result of an accident? Yes No					
2. Has a group 2 or 3 surface been used for ulcer located on the posteri						
3. Are moisture and/or incontinence being managed? .	Yes No Date of accident://					
4. Is pressure ulcer greater than 30 days?	☐ Yes ☐ No ☐ Accident Type: ☐ Auto ☐ Employment ☐ Trauma					
☐ DIABETIC ULCER/NEUROPATHIC ULCER:						
1. Has a reduction of pressure on the foot ulcer been accomplished with	appropriate modalities? LIYes LINo					
☐ VENOUS STASIS ULCER/VENOUS INSUFFICIENCY:						
1. Are compression bandages and/or garments being consistently appli						
2. Is elevation/ambulation being encouraged?	□Yes. □No					
ARTERIAL ULCER/ARTERIAL INSUFFICIENCY:	П., П.,					
1. Is pressure over the wound being relieved?	□Yes □No					
SURGICAL	2					
Wound surgically created and not represented by descriptions above	?					
2. Description of surgical procedure.						
Date of surgical procedure involving wound//  OTHER WOUND TYPE (describe):						
OTHER WOUND TTPE (describe).	<del></del>					
Ta Manualla) Daggintian	I					
<b>5c</b> Wound(s) Description						
Wound #1 Type: Age in Months:	Wound #2 Type: Age in Months:					
Wound Location:	Wound Location:					
Is there eschar tissue present in the wound?	Is there eschar tissue present in the wound?					
Has debridement been attempted in the last 10 days? Yes No	Has debridement been attempted in the last 10 days? Tyes No					
If Yes, debridement date:/	If Yes, debridement date:/					
Debridement type:	Debridement type:					
Are serial debridements required?	Are serial debridements required?					
Measurement date:/	Measurement date:/					
Length: cm Width: cm Depth: cm	Length: cm Width: cm Depth: cm					
Appearance of wound bed and color:	Appearance of wound bed and color:					
Exudate (amount and color):	Exudate (amount and color):					
Is the wound full thickness?	Is the wound full thickness?					
Is muscle, tendon or bone exposed?	Is muscle, tendon or bone exposed?					
Is there undermining?	Is there undermining?					
Location #1: cm, from to o'clock	Location #1: cm, from to o'clock					
Location #2: cm, from to o'clock	Location #2: cm, from to o'clock					
Is there tunneling/sinus?	Is there tunneling/sinus?					
Location #1: cm, at o'clock	Location #1: cm, at o'clock					
Location #2: cm, at o'clock	Location #2: cm, at o'clock					