



Please fax this form  
to KCI at

1-888-245-2295

## Letter of Medical Necessity for Excessive Supplies



Patient Name \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_ DOB: \_\_\_\_\_  
(Last): \_\_\_\_\_  
KCI Order #: \_\_\_\_\_ Acct #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cycle #: \_\_\_\_\_

KCI USA, Inc. provides V.A.C.<sup>®</sup> Therapy to the above patient and the allowed quantity of supplies for this treatment is:

15 dressings per wound per month and 10 canisters per month.

In order to obtain authorization for the supplies used during V.A.C.<sup>®</sup> Therapy in excess of the allowed quantity, Medicare requires proof of medical necessity or justification is required. The following questions provide the needed information and the patient's insurance requires that all questions be answered

1. How many wounds are being treated? \_\_\_\_\_
2. How often are the dressings changed? \_\_\_\_\_
3. Does the wound size require more than one dressing for each dressing change? Yes No  
If yes, how many dressings are used at each change? \_\_\_\_\_
4. How many cc's per day (average) of exudate does the patient's wound(s) drain? \_\_\_\_\_
5. How often is the canister changed? \_\_\_\_\_
6. Why is the patient using excessive canister/dressings? (Please explain in detail as to the patient's condition).

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Printed Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_