WOUNDCARE RESOURCES

Carter Clinical Services

FAX: 1-877-287-2007
PH: 1-855-400-2433

Patient Name: _____ Date:_____

Facility Name: _____ Fax number_____

Hospital clinic _____ Destination Therapy _____

LVAD Coordinator/Social Worker _____ Phone_____

Patient's primary insurance upon receiving the LVAD unit: _____

Dressing change frequency (circle) qd qod weekly other _____

PLEASE SUBMIT PATIENT DEMOGRAPHICS WITH ORDER FORM

VAD personnel: This order form can be customized at your request to reflect your facility formulary.

	circle selection	quantity
ST gauze sponge 2/pkg.	2"x2" 4"x4"	
antimicrobial gauze sponge	10/bowl	
antimicrobial sponge 2/pkg.	2"x2" 4"x4"	
drain sponge 2/pkg.	2"x2" 4"x4"	
antimicrobial drain sponge 2/pkg.	2"x2" 4"x4'	
Medipore H Tape	2" rolls	
1" tape	paper transparent	
Biopatch	2.5 cm/7 mm hole	
Centurion Foley Anchor		
ST gloves- pair	size: 6 7 8	
NS gloves	100/box	
ST drapes		
earloop surgical masks	50/box	
Chlorascrub Swabsticks	1.6 ml.	
Chloraprep One-Step	3.0 ml.	
Hibiclens	16 oz.	
ST saline	100 ml / 250 ml/	
3M No-Sting Barrier Film wipes	.75 ml.	
Anasept Antimicrobial Spray	8 oz.	
Centurion Management Tray #15340		

Please use blank spaces to request items not listed.

For other medical products desired or not covered by insurance:

Credit card name: _____

Credit card: Visa MC Number _____ exp. _____

Billing Address_____

_____

Assignment of Benefits

I request that all payments from any insurance carrier, including Medicare, Medicaid or private insurance company, be made on my behalf to _____ for any equipment, supplies or devices provided to me. I authorize the release of my medical information to HCFA and/or my insurance carrier and its agencies for the purpose of review of healthcare benefits for the determination of payment. This authorization will remain in effect until written notification by me or my legal representative has been received. I am responsible for any balance due not covered by my insurance. I have received a copy of the Supplier Standards and Scope of Service from _____.

Patient Rights: I have been informed of the Patient's Rights to Privacy given me by my physician's office

Patient Signature _____date_____

Physician Name _____NPI#_____

Physician Signature _____date_____

Physician Phone Number _____