Healing Biologix
Innovating Health Solutions

WOUND CARE KITS ORDER FORM

Click here to PRINT TO PDF and finalize form.

Practice name _____

Street name _____

City _____ State _____ Zipcode _____

P _____ F _____

Group NPI _____ Tax ID _____

❑ Doctor name _____ NPI _____

❑ Doctor name _____ NPI _____

❑ Doctor name _____ NPI _____

❑ Doctor name _____ NPI _____

❑ Doctor name _____ NPI _____

Patient name _____

Date of birth _____ Order date _____

Insurance Provider _____

Ins. ID # _____ Provider phone _____

Patient is currently receiving Home Health Care or other clinical assistance in the home ❑ Yes ❑ No

Patient has been provided supplier alternatives ❑ Yes ❑ No

Prescription valid for ❑ 30 days ❑ 60 days ❑ 90 days

WOUND INFORMATION					
	WOUND #1	WOUND #2	WOUND #3	WOUND #4	WOUND #5
Location / Body Part	❑ LT ❑ RT / _____	❑ LT ❑ RT / _____	❑ LT ❑ RT / _____	❑ LT ❑ RT / _____	❑ LT ❑ RT / _____
Length x Width x Depth	X X	X X	X X	X X	X X
Stage / Thickness	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full
Drainage Amount	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy
Is Wound Debrided/ Surgically Created?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Debridement Code					
Additional Wound Information					
ICD-10 Code					
Treatment Options	# of Days ❑ 7 ❑ 15 ❑ 30 Kit Code ❑ A ❑ B ❑ C	# of Days ❑ 7 ❑ 15 ❑ 30 Kit Code ❑ A ❑ B ❑ C	# of Days ❑ 7 ❑ 15 ❑ 30 Kit Code ❑ A ❑ B ❑ C	# of Days ❑ 7 ❑ 15 ❑ 30 Kit Code ❑ A ❑ B ❑ C	# of Days ❑ 7 ❑ 15 ❑ 30 Kit Code ❑ A ❑ B ❑ C

Kit #	Description	Description	# of Days
A	Collagen Powder Kit	Triple Helix 1g Collagen Powder	7
		4x4 Woundgard	15
		8oz Wound Cleanser	30
B	Collagen 1x1 Sheet Kit	Collagen 1x1 Sheet Kit	7
		2x2 Woundgard	15
		8oz Wound Cleanser	30
C	Collagen 7x7 sheet kit	Triple Helix 7x7 Collagen Pad	7
		6x8 Woundgard	15
		8oz Wound Cleanser	30

PRESCRIBER APPROVAL

By my signature below, I attest that (1) I am treating the patient identified on this form, (2) the requested supplies are medically reasonable and necessary based on my examination/treatment of the patient, (3) the patient has been instructed on the specific use of the requested supplies and is competent to perform dressing changes, and (4) I am maintaining a copy of this order for my patient's chart and will make it available upon request.

Prescriber name _____
PLEASE PRINT

Prescriber signature _____ Date_____

PATIENT APPROVAL/ASSIGNMENT OF BENEFITS

I request that payments from any insurance carrier, including Medicare, Medicaid, or private insurance company be made to the medical practice named above for any equipment, supplies, or services provided to me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to any affiliated Business Associates any information needed to determine benefits payable for these supplies or services. Furthermore, my physician has instructed me on the specific use of the requested supplies, and I am competent to utilize the supplies as instructed.

Patient signature _____ Date_____

The product and/or services provided to you are subject to the supplier standards contained in the Federal Regulations shown at 42 Code of Federal Regulation Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operations.) The full text of these standards can be obtained at https://www.ecfr.gov. (Form 051916-1)