



# WOUND CARE NOW

Durable Medical Supplies Fast - Order Form

Fax Order Form with Patient Demographics/Face Sheet to:  
Wound Care Now  
**(660) 240-9734**  
or Email to:  
**orders@woundcarenow.com**

Ordering Physician \_\_\_\_\_ NPI \_\_\_\_\_

<b>Patient Name:</b> _____
<b>Date of Birth:</b> _____ <b>Order Date:</b> _____
<b>Insurance Provider:</b> _____
<b>Ins. ID#</b> _____ <b>Provider Phone:</b> _____

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

Patient has been provided supplier alternatives:  Yes  No

Length of need:  30 Days/no refills  60 Days/Refill x1  90 Days/Refill x2

WOUND INFORMATION			
	WOUND #1	WOUND #2	WOUND #3
Frequency of dressing change?	<input type="checkbox"/> Daily <input type="checkbox"/> Every Other Day <input type="checkbox"/> Every Third Day	<input type="checkbox"/> Daily <input type="checkbox"/> Every Other Day <input type="checkbox"/> Every Third Day	<input type="checkbox"/> Daily <input type="checkbox"/> Every Other Day <input type="checkbox"/> Every Third Day
Additional Wound Information			
ICD-10 Code			

AMERX® WOUND CARE KITS	SECONDARY DRESSING	WOUND #1 DAYS REQ.	WOUND #2 DAYS REQ.	WOUND #3 DAYS REQ.
<b>KITS WITH BORDERED GAUZE</b>				
<b>HELIX3-CP® COLLAGEN POWDER WOUND CARE KIT WITH BORDERED GAUZE</b> • 1g packets Collagen Power (HCPCS - A6010) • 2x2 OR 4x4 AMERX® Bordered Gauze (HCPCS - A6219)	• 2x2 Gauze Sponge (HCPCS - A6216) • AMERIGEL® Saline Wound Wash	<input type="checkbox"/> 2"x2" <input type="checkbox"/> 4"x4"	<input type="checkbox"/> 30	<input type="checkbox"/> 30
<b>HELIX3-CM® COLLAGEN MATRIX WOUND CARE KIT WITH BORDERED GAUZE</b> • 2x2 HELIX3® Collagen Matrix (HCPCS - A6021) • 4x4 AMERX® Bordered Gauze (HCPCS - A6219)	• 2x2 Gauze Sponge (HCPCS - A6216) • AMERIGEL® Saline Wound Wash	4"x4"	<input type="checkbox"/> 30	<input type="checkbox"/> 30
<b>AMERX® CALCIUM ALGINATE WOUND CARE KIT WITH BORDERED GAUZE</b> • 2x2 AMERX® Calcium Alginate Dressing (HCPCS - A6196) • 4x4 AMERX® Bordered Gauze (HCPCS - A6219)	• 2x2 Gauze Sponge (HCPCS - A6216) • AMERIGEL® Saline Wound Wash	4"x4"	<input type="checkbox"/> 30	<input type="checkbox"/> 30

AMERX® WOUND CARE KITS	SECONDARY DRESSING	WOUND #1 DAYS REQ.	WOUND #2 DAYS REQ.	WOUND #3 DAYS REQ.
<b>KITS WITH ROLLED GAUZE</b>				
<b>HELIX3-CP® COLLAGEN POWDER WOUND CARE KIT WITH ROLLED GAUZE</b> • 1g packets Collagen Power (HCPCS - A6010) • 3 in. Rolled Gauze Dressing (HCPCS - A6446) • 4x4 Sterile Gauze Sponge (HCPCS - A6402)	• 1 in. Paper Tape (HCPCS - A4450) • AMERIGEL® Saline Wound Wash	3 in. x 4.1 yard	<input type="checkbox"/> 30	<input type="checkbox"/> 30
<b>HELIX3-CM® COLLAGEN MATRIX WOUND CARE KIT WITH ROLLED GAUZE</b> • 2x2 HELIX3® Collagen Matrix (HCPCS - A6021) • 3 in. Rolled Gauze Dressing (HCPCS - A6446) • 4x4 Sterile Gauze Sponge (HCPCS - A6402)	• 1 in. Paper Tape (HCPCS - A4450) • AMERIGEL® Saline Wound Wash	3 in. x 4.1 yard	<input type="checkbox"/> 30	<input type="checkbox"/> 30
<b>AMERX® CALCIUM ALGINATE WOUND CARE KIT WITH ROLLED GAUZE</b> • 2x2 AMERX® Calcium Alginate Dressing (HCPCS - A6196) • 3 in. Rolled Gauze Dressing (HCPCS - A6446) • 4x4 Sterile Gauze Sponge (HCPCS - A6402)	• 1 in. Paper Tape (HCPCS - A4450) • AMERIGEL® Saline Wound Wash	3 in. x 4.1 yard	<input type="checkbox"/> 30	<input type="checkbox"/> 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)