

Negative Pressure Wound Therapy (NPWT) Prescription

Please complete and Fax To: 1-877-365-1937

** Rx must be completed by the prescribing physician (provider).*

Patient Name: (Last) _____ (First) _____ (MI) _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Patient's DOB: _____ SS#: _____ - _____ - _____

I am prescribing NPWT and up to 15 dressings per wound and up to 10 canisters per month beginning on (Date) _____ for the following diagnosis (ICD 9 and narrative):

_____ Est. Length of Need: _____.

Physician Information:

** CMS policy requires the provider (physician) to sign and date this Rx prior to the delivery of the NPWT unit to the patient.*

***Physician's Signature:** (No Stamp) _____

**Date: (No Stamp) _____ * By my signature I attest that NPWT is medically necessary and all other applicable treatments have been tried or considered and ruled out. NPWT is contraindicated with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistula. I am not placing an NPWT dressing over exposed blood vessels or organs. Wound has been debrided as necessary to remove devitalized tissue and there is less than 30% eschar present.*

Physician's Name (Printed) (Last): _____ (First): _____ (MI): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____ UPIN: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____

Home Health Care Contact: _____ Phone # _____ Company _____

Delivery Site: Hospital ___ SNF/LTC ___ Home ___ Wound Care Center ___ Other ___

Pre-hospital D/C set-up _____

Provider's Goal for NPWT: Flap ___ Graft ___ Delayed Primary Closure ___ Promote formation of granulation ___ Complete epithelialization (explain why) _____

Other _____ Please describe the wound type(s) covered by this prescription (**Provide measurements/dates for each wound using NPWT**) Dressing preference if any (I.E. flat, Channel, Round 7fr or 10fr):

Pressure Ulcer Stage II/IV: _____ Surgical: _____ Flap/Graft: _____

Neuropathic Ulcer: _____ Venous Ulcer: _____ Arterial Ulcer: _____ Other: _____

Please attach wound assessment sheets; Progress Notes; Other supporting documentation * * If the clinical condition of the wound(s) require more than 15 dressings per wound or 10 canisters per month, and or NPWT is required for more than 4 months, a Letter of Medical Necessity (CMN) must be completed by the physician