Wound Care Equipment and Supplies Order Form

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Section A: Client and Provider Information (may be completed by Provider)		
Client Information		
Client Name:	Medicaid Number:	Date of Birth:
Physician Information		
Name:	Phone:	Fax No.:
License Number:	TPI:	NPI:
Supplier / DME Company Information		
Name:	Phone:	Fax No.:
Address:		
TPI:	NPI:	
I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.		
Supplier Representative Printed Name:		
Supplier Representative Signature:		Date Signed:

Section B: Wound Care Supplies (must be completed by the physician)				
Type of Request: ☐ Initial ☐ Renewal	Requested Dates of Service:			
Date the client was last seen by the physician:				
HCPCS Code	**Description of DME/Supply Requested**	**Qty**	**Diagnosis (ICD-10)**	**Brief Diagnosis Description**

Section C: Medical Necessity (must be completed by the physician)

Additional medical necessity must be stated below for any requests where the equipment/supplies are over the allowable, contains disposable suction kits, contraindication is present or does not comply with the requirements in place:

Wound Care Equipment and Supplies Order Form

Section D: Wound Description and Details (must be completed by the physician)

Current Wound Profile

Date Assessed:

Location of wound:	**Length (cm):** **Width (cm):** **Depth (cm):**
Tunneling (depth and position):	**Undermining (depth and position):**

Drainage amount (check one):	**Drainage type (check one):**	**Drainage Odor (N/A if not applicable):**
☐ Scant ☐ Moderate ☐ Heavy	☐ Serous ☐ Sanguineous ☐ Serosanguineous ☐ Purulent	

Select one and include the percentage affected: ____% Beefy ____% Dull pink/red
____% White/grey/yellow/brown slough ____% Black eschar ____% Other (please describe):

Wound Type (check one): ☐ Stage III or Stage IV pressure ulcer ☐ Preoperative myocutaneous flap/graft
☐ Recent (within 14 days) myocutaneous flap/graft ☐ DM ulcer ☐ Chronic open wound (30 days or longer)
☐ Venous Stasis ulcer ☐ Other (Please describe. If for burns, please include degree of burns):

Infection: ☐ Yes ☐ No *If "Yes," identify the prescribed medication treatment to include name, dosage, frequency, route and duration:*

Prescribed Wound Care Regimen (Please specify which supplies will be used to cleanse, dry, pack, treat, cover and secure the wound with):

Date of next visit with provider:

Frequency of Wound Care:	**Wound Vac Setting (mmHg):**

Previous Wound Profile (if Applicable)

Date Assessed:

Location of wound:	**Length (cm):** **Width (cm):** **Depth (cm):**
Tunneling (depth and position):	**Undermining (depth and position):**

Drainage amount (check one):	**Drainage type (check one):**	**Drainage Odor (N/A if not applicable):**
☐ Scant ☐ Moderate ☐ Heavy	☐ Serous ☐ Sanguineous ☐ Serosanguineous ☐ Purulent	

Select one and include the percentage affected: ____% Beefy ____% Dull pink/red
____% White/grey/yellow/brown slough ____% Black eschar ____% Other (please describe):

Wound Type (check one): ☐ Stage III or Stage IV pressure ulcer ☐ Preoperative myocutaneous flap/graft
☐ Recent (within 14 days) myocutaneous flap/graft ☐ DM ulcer ☐ Chronic open wound (30 days or longer)
☐ Venous Stasis ulcer ☐ Other (Please describe. If for burns, please include degree of burns):

Infection: ☐ Yes ☐ No *If "Yes," identify the prescribed medication treatment to include name, dosage, frequency, route and duration:*

Prescribed Wound Care Regimen (Please specify which supplies will be used to cleanse, dry, pack, treat, cover and secure the wound with):

Frequency of Wound Care:	**Wound Vac Setting (mmHg):**

Wound Care Equipment and Supplies Order Form

Section E: Documentation Requirements (must be completed by the physician)

1. Did the client receive any previous wound care treatments? ☐ Yes (complete dates below) ☐ No

   Date previous wound care treatments were initiated (month/day/year): _____

   Length of previous wound care treatments (specify if days, weeks, or months): _____

2. Was wound care therapy initiated in the hospital or skilled nursing facility (SNF)? ☐ Yes ☐ No

3. Is the client compliant with the ordered wound therapy? ☐ Yes ☐ No

   If no, please provide details and list the specific compliance concerns, including but not limited to smoking, refusing dressing changes, poor nutritional intake, etc.:

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

4. Please include the specific intervention for each compliance concern identified above that are in place to address these concerns such as, what type of repositioning, nutritional interventions, pressure offloading, special equipment/supplies etc.:

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

5. List any medical diagnosis or chronic conditions that may affect the client's wound healing (i.e., diabetes, limited mobility, incontinence, etc.):

6. Does the patient have any of the following contraindicated conditions? ☐ Yes (check one below) ☐ No

   ☐ Fistulas to the body ☐ Cancer in the margins ☐ Wound is ischemic ☐ Gangrene

   ☐ Presence of necrotic tissue, including bone ☐ No demonstrable improvement in wound over past 30 days

   ☐ Osteomylelitis (unless being treated; describe treatment below if applicable):

7. Is the wound free of necrotic tissue? ☐ Yes ☐ No

   Note: If the wound has recently been debrided, identify the type and date of debridement:

   ☐ Surgical ☐ Mechanical ☐ Enymatic ☐ Autolytic Date debridement was performed: _____

Physician Certification

I certify with my signature below that the services being supplied under this order have been reviewed and are consistent with my determination of medical necessity. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Physician Signature:	Date: