State Medical Equipment

V.A.C Therapy Insurance Authorization Form
Fax this form to State Medical Equipment at **702-538-8433**

1. Patient Information (Important: Submit demographic and/or insurance sheet)

Patient Name Last:_____ First:_____ MI: _____ Patient DOB: _____/_____/_____
(skip completing patient's home address if demographic/insurance sheet submitted)
Home Address: _____ City: _____ State: _____ Zip Code: _____Phone #: _____
Emergency Contact (if available): _____ Phone #: _____
Primary Insurance _____ Policy # _____ 2nd Insurance _____ Policy # _____

2. Prescriber Information (Complete in full or fax written prescription to include the following)

I prescribe SME V.A.C. Therapy for the ff. wound type(s): ☐ Pressure Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Venous Ulcer(s) ☐ Arterial Ulcer ☐ Surgically Created ☐ Other _____
Provide narrative description specifying wound etiology and including anatomical location(s): _____
I prescribe SME V.A.C Therapy for: 1 month 2 months 3 months 4 months other (weeks)_____
And up to 15 V.A.C Therapy dressings per wound and up to 10 V.A.C Therapy canisters per month
Starting Date of V.A.C Therapy __/__/_____(if starting therapy is blank, use my signature date as start of therapy)
Goal at the completion of SME V.A.C Therapy: ☐ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed Primary Closure (Tertiary)
Treating prescriber name Last _____ Fist _____ MI _____
Address: _____ City: _____ ST: _____ Zip: _____
Prescriber Phone: _____ Fax: _____ Email: _____ NPI: _____
☐ Request an electronically signed prescription from Prescriber *(please provide Prescriber's email address)*

Prescriber Only to Complete Original Signature Required. No Stamps
Prescriber Signature: _____ Date: ____/____/____

By signing and dating, , I attest that I am prescribing the SME V.A.C Therapy System **(DO NOT SUBSTITUTE)** as medically necessary , and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with V.A.C Therapy product, as well as the SME V.A.C Therapy Clinical Guidelines. I also understand the SME V.A.C. Therapy system contraindications: Patients with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistulas, necrotic tissue with eschar present, sensitivity to silver (V.A.C. GranuFoam Silver Dressing Only). Foam dressing (GranuffFoam, Simplace and WhiteFoam) for the V.A.C. Therapy System should not be placed deirectly in contact with exposed blood vessels, anastomotic sites, organs, or nerves. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) state that beyond the first four months of therapy, "to justify the need for each additional month of coverage, a new prescription for each month is required," in addition to supporting medical records that document medical need.

3. Supplies for Delivery <u>Please check the V.A.C Dressing(s) requested</u>

- V.A.C. Simplace EX Dressing ____Small ____Medium | • V.A.C White Foam Dressing ____Small ____ Large
- V.A.C. Simplace Dressing ____ Small ____ Medium | • V.A.C GranuFoam Bridge Dressing _____
- V.A.C GranuFoam Dressing ___Small ___Medium ___Large | • V.A.C GranuFoam Bridge CG Dressing _____

Other Dressing: _____

4. Requestor & Post-Acute Clinical Provider Information (Please complete in full)

<u>Request Facility Information</u> Requestor Name: _____ Title: _____
Requestor Facility Name: _____ Phone: _____ Fax: _____
Address: _____City: _____ State: _____ Zip: _____
Check her☐ be emailed a link to status information on this order Email Address: _____
Delivery Location: Home ☐cility/RM☐_____ Other: ☐_____
Delivery Address: _____ City: _____ State: _____ Zip: _____
SME V.A.C. System will be used in what type of facility: Private Residence WCC SNF LTAC/Rehab
Assisted Living Other: _____
Post-Acute Clinical Provider administering Dressing Changes: Name: _____ PH: _____
Address: _____ City: _____ State: _____ Zip: _____

State Medical Equipment
3950 E Sunset Rd. Ste. 112 Las Vegas NV 89120
Tel: 702-538-9555 Fax: 702-538-8433 Email: statemedicalequipment@yahoo.com

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Patient Name: _____ D.O.B.: ___/___/___ Completed By: _____

5a. Clinical Information by Wound Type

1. Was NPWT initiated in an inpatient Facility? Yes No Date Initiated: ☐ ___/____/_____
   OR has the patient been on NPWT anytime during the last 60 days? Yes No ☐ Facility Name: ____/____/_____
2. Is the patient's nutritional status compromised? Yes ☐ No ☐ Facility Name: ____/____/_____
   If Yes, Check the actions taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   Saline Gauze Hydrogel Alginate Hydrocolloid Absorptive None Other: _____
4. If other therapies were considered and ruled out, what other conditions prevented you from using other Therapies prior to applying V.A.C Therapy?
   Presence of co-morbidities High risk of infections Need for accelerated granulation tissue
   Prior history of delayed wound healing Other, please describe: _____
5. Which of the following co-morbidities apply? Diabetes Immobility Immunocompromised ESRD PVD PAD Obesity
   Smoking Depression N/A
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? Yes No N/A
7. Is Osteomyelitis present in Wound? Yes No If Yes, please indicate the following
   Antibiotic (list Name) _____ IV Antibiotics (list Name) _____ Hyperbarics
   Oxygen

Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? Yes No

8. Please provide a short narrative of possible consequences if V.A.C Therapy is not used. (**Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing): _____**

5b. Patient's Primary Wound Type

☐ Pressure Ulcer ☐ Stage III ☐ Stage IV

1. Is the patient being turned/positioned?
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? Yes No
3. Are moisture and/or incontinence being managed? Yes No
4. Is pressure ulcer greater than 30 days? Yes No

☐ **Diabetic Ulcer/Neuropathic Ulcer:**

1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? Yes No

☐ **Venous Stasis Ulcer/Venous Insufficiency:**

1. Are compression bandages and/or garments being consistently applied? Yes No
2. Is elevation/ambulation being encouraged? Yes No

☐ **Arterial Ulcer/Arterial Insufficiency:**

1. Is pressure over the wound being relieved? Yes No

☐ **Surgical**

1. Wound surgically created and not represented by descriptions above? Ye s No
2. Description of surgical procedure: _____
3. Date of surgical procedure involving wound: _____/_____/_____

OTHER WOUND TYPE (describe): _____

Please complete if Applicable
Is wound direct result of accident?
Yes No
Date of accident: ____/___/____
Accident Type:
Auto / Employment /Trauma

5c. Wound(s) Description

Wound #1 Type: _____ Age in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? Yes No
If Yes, Debridement date: ____/____/____
Are serial debridements required?
Measurement date: ____/____/____
Length: _____cm Width: ____cm Depth: _____cm
Appearance of wound bed and color: _____
Exudate (amount and color) : _____
Is the wound full thickness? Yes No
Is muscle, tendon/bone exposed? Yes No
Is there undermining? Yes No
Location #1: _____cm, at _____o'clock
Location #1: _____cm, at _____o'clock

Wound #2 Type: _____ Age in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? Yes No
If Yes, Debridement date: ____/____/____
Are serial debridements required?
Measurement date: ____/____/____
Length: _____cm Width: ____cm Depth: _____cm
Appearance of wound bed and color: _____
Exudate (amount and color) : _____
Is the wound full thickness Yes No
Is muscle, tendon/bone exposed? Yes No
Is there undermining? Yes No
Location #1: _____cm, at _____o'clock
Location #1: _____cm, at _____o'clock

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