byram healthcare

Physician's Order - TheraGauze

Referral # 164982

Customer Service (800) 334-0235, x33960 **Fax (800) 521-6291**

Acc't Name_____ Acc't Tel # (_____) _____

Patient

☐ Re-order ☐ Face Sheet Attached Order Date _____ ___ of ___

Name (L) _____ (F) _____ Ordered By _____

Address _____ Apt # _____ ☐ Male ☐ Female D.O.B. _____

City _____ St _____ Zip _____ Tel # (_____) _____

Medicare # _____ Medicaid # _____ SSN # _____

Other Ins _____ Policy # _____ Gp # _____

Ins Tel # (_____) _____ **Is the patient being seen by a home health agency?** ☐ **Yes** ☐ **No**

Diabetes? ☐ **Yes** ☐ **No** Account Fax _____ ☑ Fax Confirmation

Physician

(L) _____ (F) _____ Tel # (_____) _____

NPI # _____

Signature X _____ **Date** _____

Duration of Need ☐ **1** ☐ **2** ☐ **3** _____ **(mths)**

Wound

		Dimensions (cm's)			Drainage ✓				Thickness ✓		Debridement
Location	Type or ICD.9 code	Length	Width	Depth	Dry	Lt	Mod	Hvy	Part	Full	or Surgery Date
1)											
2)											
3)											

Dressings

Days Supply: ☐ **15** ☐ **30**

Call your local Byram Account Manager at 1-877-902-8726 for information on **TheraGauze Starter Kits**

Wound #1 **Medicare Guidelines:** Full Thickness, Dry to Light Drainage Wounds; Up-to 30/month

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) ☐ QD ☐ Q2D ☐ Q3D

Conforming Bandage Sterile ☐ 2" ☐ 3" Other Secondary: _____ ☐ Q7D ☐ Other: _____

Size

Wound #2

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) ☐ QD ☐ Q2D ☐ Q3D

Conforming Bandage Sterile ☐ 2" ☐ 3" Other Secondary: _____ ☐ Q7D ☐ Other: _____

Size

Wound #3

TheraGauze 2 x 2, Primary Dressing (SS9492268294)

Secondary Dressing (one per wound) ☐ QD ☐ Q2D ☐ Q3D

Conforming Bandage Sterile ☐ 2" ☐ 3" Other Secondary: _____ ☐ Q7D ☐ Other: _____

Size

Tape ☐ Paper ☐ Cloth ☐ 2" ☐ 3" **Other Supplies:** _____

Patient Authorization of Release of Information and Assignment of Benefits - My signature on the line below authorizes any of the following. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the Social Security Act) and/or any other Medical Insurance is correct. I authorize the release to Byram Healthcare any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Byram Healthcare on assigned claims. I authorize Byram Healthcare to submit claims to Medicare and/or any other Medical Insurance carrier. I agree to assume responsibility for any balances for supplies furnished to me by Byram Healthcare not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance and non-covered items. I authorize that photo copies shall be valid as originals.

Patient Signature (Initial order only) **X** _____ **Date** _____