

# UK DME Fax Order Form

## Wound Care

740 S Limestone, K126 Lexington, KY 40536

**PATIENT INFORMATION**

Order Date: \_\_\_\_\_ MRN: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**DME Wound Care Fax Order Form**

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND: 1) Patient Name 2) Date Prescribed 3) Physician Signature 4) NPI 5) WOPD

**DURABLE MEDICAL EQUIPMENT**

Diagnosis (Include Code) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Length of Need \_\_\_\_\_

**\*\*\*Please note this is not an exhaustive list; for additional items, please use the Other section below\*\*\***

**Bandages and Dressings:**

- 4X4 Gauze Sponges QTY: \_\_\_\_\_
- ABD Pads QTY: \_\_\_\_\_
- 4" Gauze rolls QTY: \_\_\_\_\_
- 2" Stretch Gauze Bandage QTY: \_\_\_\_\_
- 4" Stretch Gauze Bandage QTY: \_\_\_\_\_
- 4" PolyMem QTY: \_\_\_\_\_
- 6" Sof-Roll Padding QTY: \_\_\_\_\_
- 4"Elastic Wraps QTY: \_\_\_\_\_
- 6"Elastic Wraps QTY: \_\_\_\_\_

**Adhesives and Tapes:**

- 1" Transpore Tape QTY: \_\_\_\_\_
- 1" Silicone Tape QTY: \_\_\_\_\_
- 4"Self-Adherent Wrap QTY: \_\_\_\_\_

**Additional Wound Care Items Not Listed:**

- \_\_\_\_\_ QTY: \_\_\_\_\_
- \_\_\_\_\_ QTY: \_\_\_\_\_
- \_\_\_\_\_ QTY: \_\_\_\_\_
- \_\_\_\_\_ QTY: \_\_\_\_\_
- \_\_\_\_\_ QTY: \_\_\_\_\_

**Saline and Cleansers:**

*\*Please include the mL per supply change\**

- Saline Sticks QTY: \_\_\_\_\_
- 250 mL bottle QTY: \_\_\_\_\_
- 100 mL bottle QTY: \_\_\_\_\_

**Specialty Dressings:**

- Rooke Below-Knee Protector QTY: \_\_\_\_\_
- Rooke Above-Knee Protector QTY: \_\_\_\_\_

**Generic substitutions are allowed: Yes \_\_\_\_\_ No \_\_\_\_\_**

**\*\*Patient is required to change their wound supplies \_\_\_\_\_ time(s) per \_\_\_\_\_. \*\***

**PRESCRIBING PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Provider Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

**STATEMENT OF CONFIDENTIALITY**

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