ABCO MEDICAL SUPPLY

Please forward all correspondence to:
CMN (Certificate of Medical Necessity)
ABCO Medical Supply
Ph: (888) 899-8881 • Fax: (888) 606-4866 • ABCOMedicalSupply.com

Patient Name: _____ Insurance ID#: _____
Address: _____
City *State* *Zip*
Patient Phone: _____ DOB: _____ SSN #: _____
Patient Height: _____ Patient Weight: _____ *(Both are required for mobility devices)*

NPWT PRODUCTS ORDER FORM

PRODUCTS:

❑ Negative Pressure Wound Therapy System with 15 Kits (A6550) & 10 Canisters (A7000)
Length of need: ❑ _____ months

THERAPY SETTINGS:

❑ Continuous Mode (40-200 mmHg) _____ mmHg
❑ Variable Intermittent Mode
Low Pressure (40-200 mmHg) _____ mmHg
Cycle Time (1 minute increments) _____
High Pressure (40-200 mmHg) _____ mmHg
Cycle Time (1 minute increments) _____

Notes: _____
Other orders: _____

DIAGNOSIS: *(continued on p2)*

Wound type: _____ Diagnosis code(s): _____ Stage (if applicable): _____
Other contributing diagnosis: _____

CLINICAL INFORMATION:

Is the patient being seen regularly by a nurse, physician or other licensed practitioner?	❑ Y	❑ N	❑ N/A
Has a care plan been established including ongoing nutritional assessments and consistent interventions?	❑ Y	❑ N	❑ N/A
Is the wound full thickness?	❑ Y	❑ N	❑ N/A
Is the moisture/incontinence being appropriately managed?	❑ Y	❑ N	❑ N/A
Has the wound environment remained moist?	❑ Y	❑ N	❑ N/A
Is there 20% or less eschar in the wound?	❑ Y	❑ N	❑ N/A
Has NPWT therapy ever been utilized prior? If Yes, date: _____	❑ Y	❑ N	❑ N/A

Has previous alternative treatment been tried prior to application of NPWT?
If yes, what has been tried: _____

Provider Information

Physician Name: _____ NPI: _____
Phone: _____ Fax: _____
Address: _____
City *State* *Zip*
Attending Physician Signature: _____ Date: _____
(Original signature ONLY—no stamps)

INSTRUCTIONS: Please fill out this form and fax demographics, office visit notes and form to ABCO Medical Supply at (888) 606-4866.