CHC SOLUTIONS, INC.

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COMPRESSION ORDER FORM

Please attach face sheet w/ patient demographics & insurance info*

Patient Information

Patient Name: _____

DOB: _____ /_____ /_____ Start Date: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact Name/Phone Number: _____

Length of Need: _____ Months

**** Medicare and Medicare Replacement Plans require patients have an open, measurable venous stasis ulcer. If patient does not have an open venous stasis ulcer, we will discuss private pay with the patient. ****

Wound Assessment

ICD-10 Code	Wound Location	Has the wound ever been debrided?	Length x Width x Depth	Stage/Thickness	Drainage
1.		☐ YES ☐ NO		☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full	☐ None ☐ Min ☐ Mod ☐ Hvy
2.		☐ YES ☐ NO		☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full	☐ None ☐ Min ☐ Mod ☐ Hvy

Product Selection

Ready-to-Wear Stockings

Medicare will only cover compression above 30mmHg

☐ JOBST UlcerCARE
- 40-50mmHg
- Closed Toe
☐ Black ☐ Beige
☐ Zipper Option **(Beige Only)**

☐ JOBST Relief Stocking
- 30-40mmHg
☐ Open ☐ Closed
- Beige

☐ Carolon Multi-Layer Stocking
- 30-40mmHg
- Closed
☐ Black ☐ Beige

☐ Mediven Dual Layer System
- 30-40mmHg
- Closed
- Beige

☐ JOBST FarrowWrap Basic
- Wrap
- Beige

☐ JOBST FarrowWrap 4000
- Wrap
- Beige

☐ Circaid JuxtaLite HD
- Wrap
☐ Black ☐ Beige

☐ Compreflex Transition (Lite)
- Wrap
☐ Black ☐ Beige

☐ Circaid JuxtaLite
- Wrap
☐ Black ☐ Beige

	Left Leg	Right Leg
Ankle Circumference		
Calf Circumference		
Length (From Knee to Floor)		

Quantity (Pair): _____ **Number of Refills:** _____

Order Date: _____ /_____ /_____ **Start Date:** _____ /_____ /_____

Referral Information

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI #: _____ Phone: (_____) _____ - _____ Ext. _____

Physician Signature: _____ Date: _____ /_____ /_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____ /_____ /_____

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.

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