

****Please attach face sheet w/ patient demographics, wound assessment & 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. ****

Product Selection

Ready-to-Wear Stockings

Medicare will only cover compression above 30mmHg

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> JOBST UlcerCARE
- 40-50mmHg
- Closed Toe
<input type="checkbox"/> Black <input type="checkbox"/> Beige
<input type="checkbox"/> Zipper Option (Beige Only) | <input type="checkbox"/> JOBST Relief Stocking
- 30-40mmHg
<input type="checkbox"/> Open <input type="checkbox"/> Closed
- Beige | <input type="checkbox"/> Carolon Multi-Layer Stocking
- 30-40mmHg
- Closed
<input type="checkbox"/> Black <input type="checkbox"/> Beige | <input type="checkbox"/> Mediven Dual Layer System
- 30-40mmHg
- Closed
- Beige |
| <input type="checkbox"/> JOBST FarrowWrap Basic
- Wrap
- Beige | <input type="checkbox"/> JOBST FarrowWrap 4000
- Wrap
<input type="checkbox"/> Black <input type="checkbox"/> Beige | <input type="checkbox"/> Circaid JuxtaLite HD
- Wrap
<input type="checkbox"/> Black <input type="checkbox"/> Beige | <input type="checkbox"/> Compreflex Transition (Lite)
- Wrap
<input type="checkbox"/> Black <input type="checkbox"/> Beige |
| <input type="checkbox"/> Circaid JuxtaLite
- Wrap
<input type="checkbox"/> Black <input type="checkbox"/> 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 below, 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.