3M™ V.A.C.® Therapy Insurance Authorization Form

Snapshot Instructions

Use these instructions to guide you on how to fill out each section. This is to help ensure there are no delivery delays.

Submit demographics and/or insurance sheet.

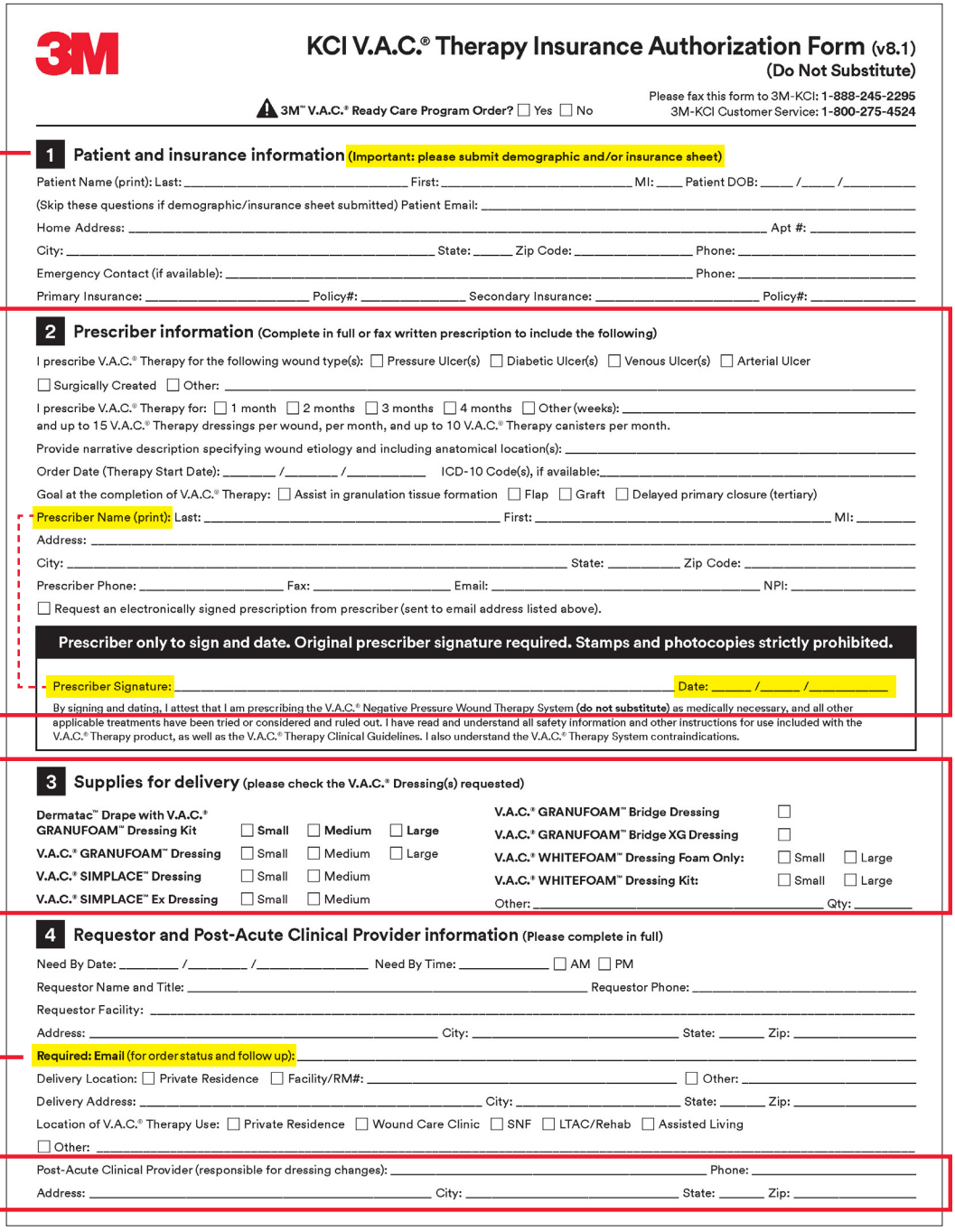
Required to be completely filled out and must be signed by prescriber.

The printed prescriber name **must** match signature name. Prescriber Signature Date must be ON or BEFORE the Order Date.

Information can be found in Wound Care Notes or Op Report.

Requestor Email is required to receive status updates.

Ensure this has the Post-Acute facility (agency responsible for dressing changes) information patient is going to.



KCI V.A.C.® Therapy Insurance Authorization Form (v8.1)
(Do Not Substitute)

3M™ V.A.C.® Ready Care Program Order? ☐ Yes ☐ No

Please fax this form to 3M-KCI: 1-888-245-2295
3M-KCI Customer Service: 1-800-275-4524

1 Patient and insurance information (Important: please submit demographic and/or insurance sheet)

Patient Name (print): Last: _____ First: _____ MI: ___ Patient DOB: ____ /____ /_____

(Skip these questions if demographic/insurance sheet submitted) Patient Email: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Emergency Contact (if available): _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Secondary Insurance: _____ Policy#: _____

2 Prescriber information (Complete in full or fax written prescription to include the following)

I prescribe V.A.C.® Therapy for the following wound type(s): ☐ Pressure Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Venous Ulcer(s) ☐ Arterial Ulcer

☐ Surgically Created ☐ Other: _____

I prescribe V.A.C.® Therapy for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other (weeks): _____
and up to 15 V.A.C.® Therapy dressings per wound, per month, and up to 10 V.A.C.® Therapy canisters per month.

Provide narrative description specifying wound etiology and including anatomical location(s): _____

Order Date (Therapy Start Date): _____ /_____ /_____ ICD-10 Code(s), if available: _____

Goal at the completion of V.A.C.® Therapy: ☐ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed primary closure (tertiary)

Prescriber Name (print): Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Fax: _____ Email: _____ NPI: _____

☐ Request an electronically signed prescription from prescriber (sent to email address listed above).

Prescriber only to sign and date. Original prescriber signature required. Stamps and photocopies strictly prohibited.

Prescriber Signature: _____ Date: _____ /_____ /_____

By signing and dating, I attest that I am prescribing the V.A.C.® Negative Pressure Wound Therapy System (**do not substitute**) as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy System contraindications.

3 Supplies for delivery (please check the V.A.C.® Dressing(s) requested)

Dermatac™ Drape with V.A.C.® GRANUFOAM™ Dressing Kit	☐ Small	☐ Medium	☐ Large	V.A.C.® GRANUFOAM™ Bridge Dressing	☐	
V.A.C.® GRANUFOAM™ Dressing	☐ Small	☐ Medium	☐ Large	V.A.C.® GRANUFOAM™ Bridge XG Dressing	☐	
V.A.C.® SIMPLACE™ Dressing	☐ Small	☐ Medium		V.A.C.® WHITEFOAM™ Dressing Foam Only:	☐ Small	☐ Large
V.A.C.® SIMPLACE™ Ex Dressing	☐ Small	☐ Medium		V.A.C.® WHITEFOAM™ Dressing Kit:	☐ Small	☐ Large

Other: _____ Qty: _____

4 Requestor and Post-Acute Clinical Provider information (Please complete in full)

Need By Date: _____ /_____ /_____ Need By Time: _____ ☐ AM ☐ PM

Requestor Name and Title: _____ Requestor Phone: _____

Requestor Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Required: Email (for order status and follow up): _____

Delivery Location: ☐ Private Residence ☐ Facility/RM#: _____ ☐ Other: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____

Location of V.A.C.® Therapy Use: ☐ Private Residence ☐ Wound Care Clinic ☐ SNF ☐ LTAC/Rehab ☐ Assisted Living

☐ Other: _____

Post-Acute Clinical Provider (responsible for dressing changes): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

You can find this in the H&P.

Additional documentation that will be required to bill insurance:

- Surgical Wounds will require Operative Report
- Chronic Ulcers will require Tried and Failed Therapies
- Diabetic Ulcer will require Offloading, Diabetic Management Program
- Pressure Injury will require Age of Wound and Use of Group 2 or 3 Support Surface

You can find this information in Wound Care Notes or Op Report, **measurements must be within 7 days and MUST include a depth.**

Patient Name: _____ Patient DOB: _____ /_____ /_____ Completed By: _____

5a Clinical information by wound type

1. Was NPWT initiated in an inpatient facility? ☐ Yes ☐ No Date Initiated: _____ /_____ /_____
   OR has the patient been on NPWT anytime during the last 60 days? ☐ Yes ☐ No Facility Name: _____
2. Is the patient's nutritional status compromised? ☐ Yes ☐ No Facility City/State: _____
   If Yes, check the action taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   ☐ Saline Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ None ☐ Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue ☐ Prior history of delayed wound healing
   ☐ Other (please describe): _____
5. Which of the following co-morbidities apply? ☐ Diabetes ☐ ESRD ☐ PVD ☐ PAD ☐ Immunocompromised ☐ Obesity ☐ Depression ☐ Smoking
   ☐ Para ☐ Quad ☐ WC Dependent ☐ Bedbound ☐ Not Applicable
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ Not Applicable
7. Is Osteomyelitis present in wound? ☐ Yes ☐ No If yes, please indicate the following:
   ☐ Antibiotic (list name): _____ ☐ IV Antibiotics (list name): _____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
8. Please provide a short narrative of possible consequences if V.A.C.® Therapy is not used. (Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):

5b Patient's primary wound type (Please select one)

☐ **PRESSURE ULCER** ☐ Stage III ☐ Stage IV
1. Is the patient being turned/positioned? ☐ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Are moisture and/or incontinence being managed? ☐ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No

☐ **DIABETIC ULCER/NEUROPATHIC ULCER**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY**
1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **ARTERIAL ULCER/ARTERIAL INSUFFICIENCY**
1. Is pressure over the wound being relieved? ☐ Yes ☐ No

☐ **SURGICAL**
1. Was the wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of the surgical procedure: _____
3. Date of surgical procedure involving wound: _____ /_____ /_____

☐ **OTHER WOUND TYPE (Describe):** _____

Please complete if applicable:
Is wound a direct result of an accident? ☐ Yes ☐ No
If Yes, complete the following:
Date of Accident: _____ /_____ /_____
Accident type: ☐ Auto ☐ Employment ☐ Trauma

5c Wound(s) description

Wound #1 Type: _____ Age (Months): _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ /_____ /_____
Length: _____ cm **Width:** _____ cm **Depth:** _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

Wound #2 Type: _____ Age (Months): _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ /_____ /_____
Length: _____ cm **Width:** _____ cm **Depth:** _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

Access the KCI V.A.C.® Therapy Insurance Authorization Form at 3Mexpress.com.

Please fax the completed form and any additional documentation to 1-888-245-2295.

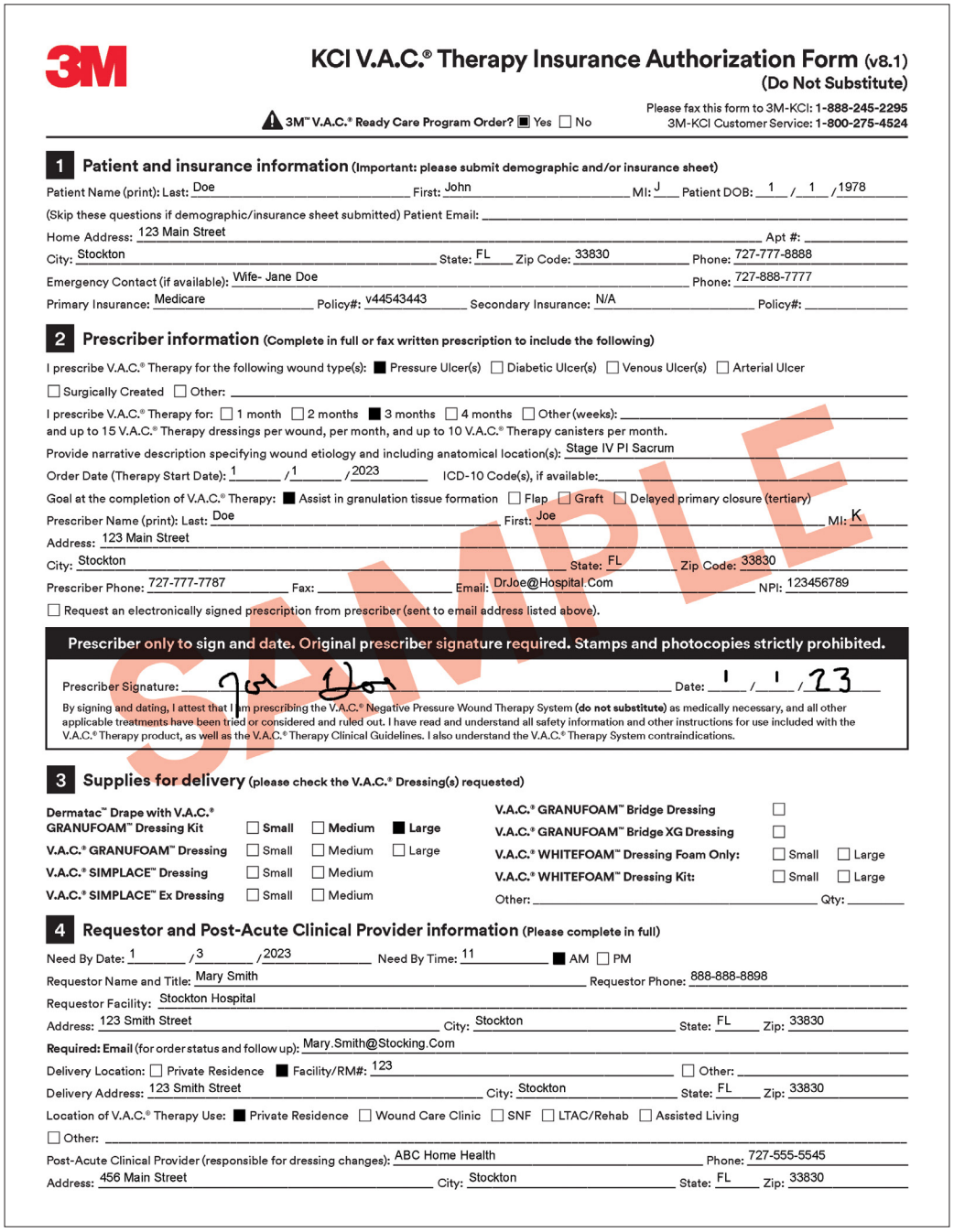
Supporting documents needed: Patient Face Sheet, History and Physical, OP Note and/or recent Progress Note.

For additional questions, contact 1-800-275-4524.

3M™ V.A.C.® Therapy Insurance Authorization Form

Customer Sample

Now, by following the Snapshot Instructions from pages 1 and 2, see the customer sample form here.



3M

KCI V.A.C.® Therapy Insurance Authorization Form (v8.1)
(Do Not Substitute)

⚠ 3M™ V.A.C.® Ready Care Program Order? ■ Yes ☐ No

Please fax this form to 3M-KCI: **1-888-245-2295**
3M-KCI Customer Service: **1-800-275-4524**

1 Patient and insurance information (Important: please submit demographic and/or insurance sheet)

Patient Name (print): Last: Doe First: John MI: J Patient DOB: 1 / 1 / 1978

(Skip these questions if demographic/insurance sheet submitted) Patient Email: _____

Home Address: 123 Main Street Apt #: _____

City: Stockton State: FL Zip Code: 33830 Phone: 727-777-8888

Emergency Contact (if available): Wife- Jane Doe Phone: 727-888-7777

Primary Insurance: Medicare Policy#: v44543443 Secondary Insurance: N/A Policy#: _____

2 Prescriber information (Complete in full or fax written prescription to include the following)

I prescribe V.A.C.® Therapy for the following wound type(s): ■ Pressure Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Venous Ulcer(s) ☐ Arterial Ulcer

☐ Surgically Created ☐ Other: _____

I prescribe V.A.C.® Therapy for: ☐ 1 month ☐ 2 months ■ 3 months ☐ 4 months ☐ Other (weeks): _____
and up to 15 V.A.C.® Therapy dressings per wound, per month, and up to 10 V.A.C.® Therapy canisters per month.

Provide narrative description specifying wound etiology and including anatomical location(s): Stage IV PI Sacrum

Order Date (Therapy Start Date): 1 / 1 / 2023 ICD-10 Code(s), if available: _____

Goal at the completion of V.A.C.® Therapy: ■ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed primary closure (tertiary)

Prescriber Name (print): Last: Doe First: Joe MI: K

Address: 123 Main Street

City: Stockton State: FL Zip Code: 33830

Prescriber Phone: 727-777-7787 Fax: _____ Email: DrJoe@Hospital.Com NPI: 123456789

☐ Request an electronically signed prescription from prescriber (sent to email address listed above).

Prescriber only to sign and date. Original prescriber signature required. Stamps and photocopies strictly prohibited.

Prescriber Signature: Joe Doe Date: 1 / 1 / 23

By signing and dating, I attest that I am prescribing the V.A.C.® Negative Pressure Wound Therapy System **(do not substitute)** as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy System contraindications.

3 Supplies for delivery (please check the V.A.C.® Dressing(s) requested)

Dermatac™ Drape with V.A.C.® GRANUFOAM™ Dressing Kit	☐ Small	☐ Medium	■ Large
V.A.C.® GRANUFOAM™ Dressing	☐ Small	☐ Medium	☐ Large
V.A.C.® SIMPLACE™ Dressing	☐ Small	☐ Medium	
V.A.C.® SIMPLACE™ Ex Dressing	☐ Small	☐ Medium	

V.A.C.® GRANUFOAM™ Bridge Dressing	☐	
V.A.C.® GRANUFOAM™ Bridge XG Dressing	☐	
V.A.C.® WHITEFOAM™ Dressing Foam Only:	☐ Small	☐ Large
V.A.C.® WHITEFOAM™ Dressing Kit:	☐ Small	☐ Large

Other: _____ Qty: _____

4 Requestor and Post-Acute Clinical Provider information (Please complete in full)

Need By Date: 1 / 3 / 2023 Need By Time: 11 ■ AM ☐ PM

Requestor Name and Title: Mary Smith Requestor Phone: 888-888-8898

Requestor Facility: Stockton Hospital

Address: 123 Smith Street City: Stockton State: FL Zip: 33830

Required: Email (for order status and follow up): Mary.Smith@Stocking.Com

Delivery Location: ☐ Private Residence ■ Facility/RM#: 123 ☐ Other: _____

Delivery Address: 123 Smith Street City: Stockton State: FL Zip: 33830

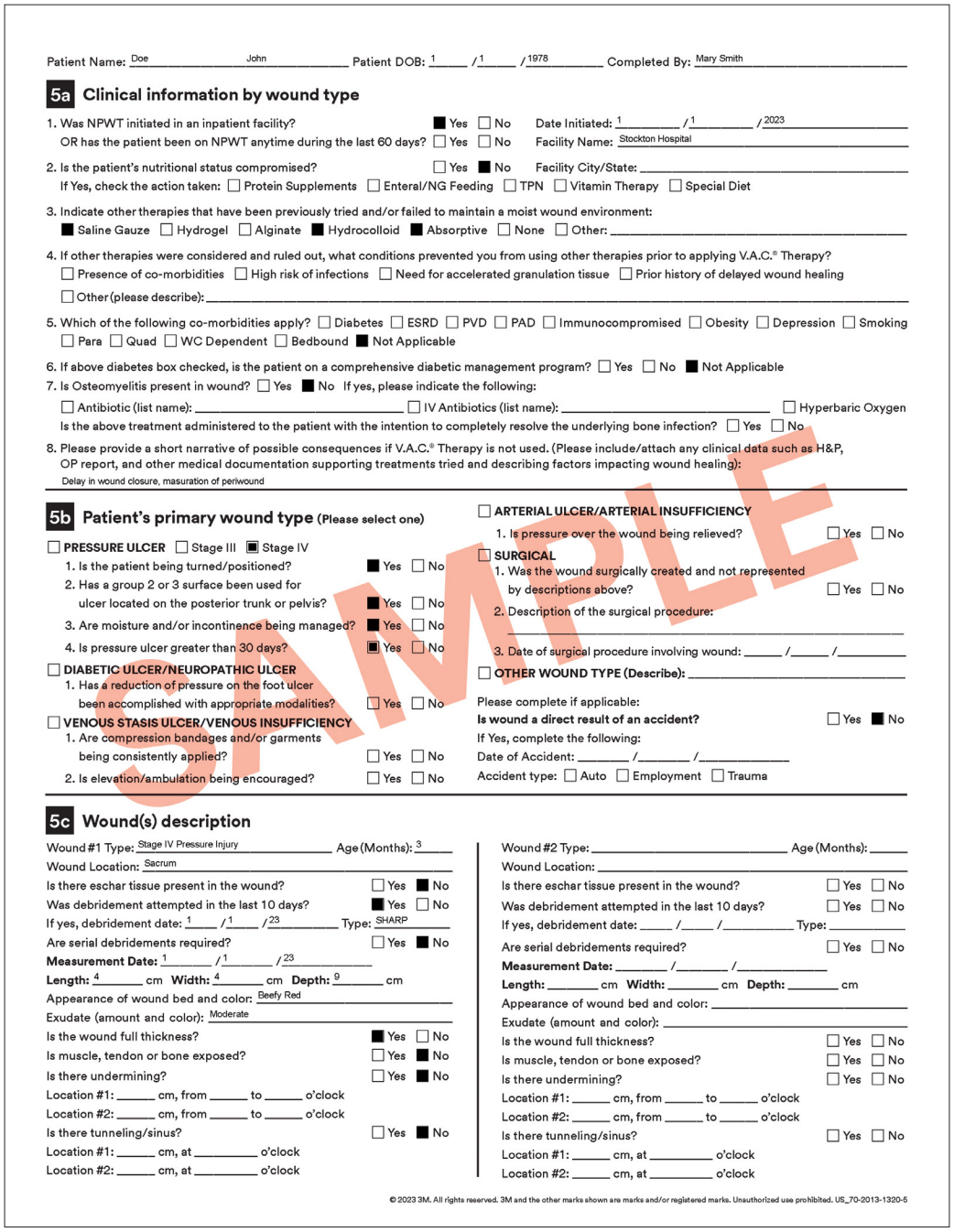
Location of V.A.C.® Therapy Use: ■ Private Residence ☐ Wound Care Clinic ☐ SNF ☐ LTAC/Rehab ☐ Assisted Living

☐ Other: _____

Post-Acute Clinical Provider (responsible for dressing changes): ABC Home Health Phone: 727-555-5545

Address: 456 Main Street City: Stockton State: FL Zip: 33830

SAMPLE



Patient Name: Doe John Patient DOB: 1 / 1 / 1978 Completed By: Mary Smith

5a Clinical information by wound type

1. Was NPWT initiated in an inpatient facility? ■ Yes ☐ No Date Initiated: 1 / 1 / 2023
   OR has the patient been on NPWT anytime during the last 60 days? ☐ Yes ☐ No Facility Name: Stockton Hospital
2. Is the patient's nutritional status compromised? ☐ Yes ■ No Facility City/State: _____
   If Yes, check the action taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   ■ Saline Gauze ☐ Hydrogel ☐ Alginate ■ Hydrocolloid ■ Absorptive ☐ None ☐ Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue ☐ Prior history of delayed wound healing
   ☐ Other (please describe): _____
5. Which of the following co-morbidities apply? ☐ Diabetes ☐ ESRD ☐ PVD ☐ PAD ☐ Immunocompromised ☐ Obesity ☐ Depression ☐ Smoking
   ☐ Para ☐ Quad ☐ WC Dependent ☐ Bedbound ■ Not Applicable
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ■ Not Applicable
7. Is Osteomyelitis present in wound? ☐ Yes ■ No If yes, please indicate the following:
   ☐ Antibiotic (list name): _____ ☐ IV Antibiotics (list name): _____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
8. Please provide a short narrative of possible consequences if V.A.C.® Therapy is not used. (Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):
   Delay in wound closure, masuration of periwound

5b Patient's primary wound type (Please select one)

☐ **PRESSURE ULCER** ☐ Stage III ■ Stage IV
1. Is the patient being turned/positioned? ■ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ■ Yes ☐ No
3. Are moisture and/or incontinence being managed? ■ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ■ Yes ☐ No

☐ **DIABETIC ULCER/NEUROPATHIC ULCER**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY**
1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **ARTERIAL ULCER/ARTERIAL INSUFFICIENCY**
1. Is pressure over the wound being relieved? ☐ Yes ☐ No

☐ **SURGICAL**
1. Was the wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of the surgical procedure: _____
3. Date of surgical procedure involving wound: _____ / _____ / _____

☐ **OTHER WOUND TYPE (Describe):** _____

Please complete if applicable:
Is wound a direct result of an accident? ☐ Yes ■ No
If Yes, complete the following:
Date of Accident: _____ / _____ / _____
Accident type: ☐ Auto ☐ Employment ☐ Trauma

5c Wound(s) description

Wound #1 Type: Stage IV Pressure Injury Age (Months): 3
Wound Location: Sacrum
Is there eschar tissue present in the wound? ☐ Yes ■ No
Was debridement attempted in the last 10 days? ■ Yes ☐ No
If yes, debridement date: 1 / 1 / 23 Type: SHARP
Are serial debridements required? ☐ Yes ■ No
Measurement Date: 1 / 1 / 23
Length: 4 cm **Width:** 4 cm **Depth:** 9 cm
Appearance of wound bed and color: Beefy Red
Exudate (amount and color): Moderate
Is the wound full thickness? ■ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ■ No
Is there undermining? ☐ Yes ■ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ■ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

Wound #2 Type: _____ Age (Months): _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ / _____ / _____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ / _____ / _____
Length: _____ cm **Width:** _____ cm **Depth:** _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

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Supporting documents needed: Patient Face Sheet, History and Physical, OP Note and/or recent Progress Note.

For additional questions, contact 1-800-275-4524.

3M Company
2510 Conway Ave
St. Paul, MN 55144 USA

Phone 1-800-275-4524 (NPWT products)
1-800-228-3957
Web 3M.com/medical

NOTE: Specific indications, contraindications, warnings, precautions and safety information exist for these products and therapies. Please consult a clinician and product instructions for use prior to application. Rx only.