

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.

	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						
Submit demographics and/or ———	1 Patient and insurance information (Important: please submit demographic an	d/or insurance shoot)						
nsurance sheet.	Patient Name (print): Last: First: First:							
insurance sneet.	(Skip these questions if demographic/insurance sheet submitted) Patient Email:							
		Apt #:						
	City: State: Zip Code:							
		Phone:						
	Primary Insurance:Policy#:Secondary Insurance:							
Required to be completely	2 Prescriber information (Complete in full or fax written prescription to include the							
filled out and must be signed	I prescribe V.A.C.® Therapy for the following wound type(s): Pressure Ulcer(s) Diabetic Ulcer(s)	Venous Ulcer(s) Arterial Ulcer						
by prescriber.	Surgically Created Other:							
	I prescribe V.A.C.® Therapy for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other (wee and up to 15 V.A.C.® Therapy dressings per wound, per month, and up to 10 V.A.C.® Therapy canister							
	Provide narrative description specifying wound etiology and including anatomical location(s):	is per month.						
	Order Date (Therapy Start Date):/ ICD-10 Code(s), if available:	:						
	Goal at the completion of V.A.C.® Therapy: Goal at the completion of V.A.C.® Therapy: Granulation tissue formation Flap Granulation Gr							
The printed prescriber name must	First:First:							
natch signature name. Prescriber	Address:							
Signature Date must be ON or	City: State	e: Zip Code:						
•	Prescriber Phone: Fax: Email:	NPI:						
BEFORE the Order Date.	Request an electronically signed prescription from prescriber (sent to email address listed above)	ı.						
	Prescriber only to sign and date. Original prescriber signature required. Sta	mps and photocopies strictly prohibited						
	Prescriber only to sign and date. Original prescriber signature required. Sta	imps 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 I							
	applicable treatments have been tried or considered and ruled out. I have read and understand all safety inforn V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy							
nformation can be found ————	3 Supplies for delivery (please check the V.A.C.* Dressing(s) requested)							
in Wound Care Notes or		DAM [™] Bridge Dressing						
Op Report.		DAM" Bridge XG Dressing						
		AM [™] Dressing Foam Only: Small Large						
		AM [™] Dressing Kit:						
	V.A.C.* SIMPLACE** Ex Dressing	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: R							
	Requestor Facility:	•						
	Address: City:							
Requestor Email is required ————	Required: Email (for order status and follow up):							
o receive status updates.	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/I	Rehab 🗌 Assisted Living						
	Other:							
Ensure this has the Post-Acute ———	Post-Acute Clinical Provider (responsible for dressing changes):	Phone:						
facility (agency responsible for	Address: City:	State: Zip:						
dressing changes) information								
patient is going to.								

	Patient Name: Patient DOB: / / Completed By:	_					
You can find this in the H&P.	5a Clinical information by wound type						
	1. Was NPWT initiated in an inpatient facility?	_					
	2. Is the patient's nutritional status compromised?						
	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 Smokin Para Quad WC Dependent Bedbound Not Applicable	ng					
	6. If above diabetes box checked, is the patient on a comprehensive diabetic management program?						
	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):						
Additional documentation that	ARTERIAL ULCER/ARTERIAL INSUFFICIENCY	- 1					
will be required to bill insurance:	5b Patient's primary wound type (Please select one) 1. Is pressure over the wound being relieved?	0					
•	□ PRESSURE ULCER □ Stage III □ Stage IV □ SURGICAL 1. Is the patient being turned/positioned? □ Yes □ No □ 1. West have understand and not represented.						
 Surgical Wounds will require 	1. Is the patient being turned/positioned?	.					
Operative Report	ulcer located on the posterior trunk or pelvis?						
 Chronic Ulcers will require Tried 	3. Are moisture and/or incontinence being managed?	_					
and Failed Therapies	4. Is pressure ulcer greater than 30 days? Yes No 3. Date of surgical procedure involving wound://	_					
Diabetic Ulcer will require	□ DIABETIC ULCER/NEUROPATHIC ULCER 1. Has a reduction of pressure on the foot ulcer	-					
Offloading, Diabetic	been accomplished with appropriate modalities? Yes No Please complete if applicable: VENOUS STASIS ULCER/VENOUS INSUFFICIENCY Is wound a direct result of an accident? Yes No	io					
Management Program	1. Are compression bandages and/or garments If Yes, complete the following:						
	being consistently applied?						
Pressure Injury will require	2. Is elevation/ambulation being encouraged? Yes No Accident type: Auto Employment Trauma						
Age of Wound and Use of Group 2 or 3 Support Surface	5c Wound(s) description						
	Wound #1 Type: Age (Months): Age (Months): Age (Months):	_					
	Wound Location: Wound Location:	-					
	Is there eschar tissue present in the wound? Yes No Is there eschar tissue present in the wound? Yes No Was debridement attempted in the last 10 days? Yes No Was debridement attempted in the last 10 days? Yes No						
	If yes, debridement date: / Type: Type: Type: Type: Type:	°					
	Are serial debridements required?	-					
V (* 141. ; (* 4. ;	Measurement Date: / / Measurement Date: / /	•					
You can find this information in	Length: cm Width: cm Depth: cm Length: cm Width: cm Depth: cm						
Wound Care Notes or Op Report,	Appearance of wound bed and color: Appearance of wound bed and color: Exudate (amount and color):	-					
measurements must be within	Exadate (amount and color).	-					
7 days and MUST include a depth.	Is the wound full thickness? Yes No Is the wound full thickness? Yes No Is muscle, tendon or bone exposed? Yes No Is muscle, tendon or bone exposed? Yes No						
	Is there undermining?						
	Location #1: cm, from to o'clock Location #1: cm, from to o'clock						
	Location #2:cm, fromtoo'clock Location #2:cm, fromtoo'clock						
	Is there tunneling/sinus? Yes No Is there tunneling/sinus? Yes No Location #1: cm, at o'clock	0					
	Location #2: cm, at o'clock Location #2: cm, at o'clock	\dashv					

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

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

Progress Note.

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.

				erapy Insurance	, radioi 12a		Substitute
	≜ зм	l [™] V.A.C.* Read	y Care Program	Order? ■ Yes □ No	Please fax this form 3M-KCI Custon		
1 Patient and insuran	ce inforn	nation (Impo	rtant: please su	bmit demographic and/or in:	surance sheet)		
Patient Name (print): Last: Doe			First: John		MI: Patient DOB:	_1_/_1_	/1978
Skip these questions if demograph	nic/insurance	sheet submitte	ed) Patient Emai	l:			
Home Address: 123 Main Street						Apt #:	
City: Stockton			State:	FL Zip Code: 33830	Phone: 727	7-777-8888	
Emergency Contact (if available):	Wife- Jane D	loe			Phone: 727	7-888-7777	
Primary Insurance: Medicare		Policy#: <u>v44</u>	543443	Secondary Insurance: N/A		Policy#:	
2 Prescriber informat	ion (Comp	lete in full or fa	ax written presc	ription to include the followi	ng)		
prescribe V.A.C.® Therapy for the	following wo	und type(s):	Pressure Ulcer(s) 🗌 Diabetic Ulcer(s) 🗌 Ve	enous Ulcer(s) 🗌 Arte	erial Ulcer	
Surgically Created Other: _							
prescribe V.A.C.® Therapy for:							
and up to 15 V.A.C.® Therapy dress						and the same of	
Provide narrative description spec	ifying wound	d etiology and i			Sacrum		
Order Date (Therapy Start Date): 1				10 Code(s), if available:			
Goal at the completion of V.A.C.® T		Assist in granula	ation tissue form		Delayed primary closu		1/
Prescriber Name (print): Last: Doe				First: Joe			MI: K
Address: 123 Main Street							
City: Stockton				State: FL	Zip Code: 33	3830	
,		7		- Otate:			
rescriber Phone: <u>727-777-7787</u>	ed prescription		ber (sent to ema	ail: DrJoe@Hospital.Com il address listed above).		NPI: 123456	
Prescriber Phone: 727-777-7787 Request an electronically signe Prescriber only to sign a Prescriber Signature: By signing and dating, lattest that I	and date.	Original pres	scriber signa	ail: DrJoe@Hospital Com il address listed above). ture required. Stamps a	and photocopies Date:	strictly pro	phibited.
Prescriber Phone: 727-777-7787 Request an electronically signe Prescriber only to sign a	and date. (on from prescrib	scriber signa scriber signa attive Pressure Wo	ail: DrJoe@Hospital Com il address listed above). ture required. Stamps a ound Therapy System (do not subs derstand all safety information ar	Date:	strictly pro	phibited.
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		·/	_ / <u>1978</u> Comple	ted By: Mary Smith		
5a Clinical information by wound type	e					
 Was NPWT initiated in an inpatient facility? OR has the patient been on NPWT anytime during th 	e last 60 days?	Yes No		/ 1 / 2023 n Hospital		
Is the patient's nutritional status compromised? If Yes, check the action taken: Protein Supplement	ts 🗌 Enteral	☐ Yes ■ No /NG Feeding ☐		y Special Diet		
3. Indicate other therapies that have been previously tri ■ Saline Gauze ☐ Hydrogel ☐ Alginate ■ Hydrogel				:		
4. If other therapies were considered and ruled out, wh Presence of co-morbidities High risk of infect						
Other (please describe):						
5. Which of the following co-morbidities apply? ☐ Di			PAD Immunocompro	mised 🗌 Obesity 🗌 Depre	∍ssion □ S	mokin
6. If above diabetes box checked, is the patient on a co 7. Is Osteomyelitis present in wound? ☐ Yes ■ No □				No Not Applicable		
		IV Antibiotics (li		П	Hyperbaric (Oxvae
Is the above treatment administered to the patient wi						CAYGE
8. Please provide a short narrative of possible consequ						
OP report, and other medical documentation supportion belay in wound closure, masuration of periwound					, , , , , , , , , , , , , , , , , , ,	
El Dation Commission of the Co		□AF	TERIAL ULCER/ARTERIA	LINSUFFICIENCY		
Patient's primary wound type (Plea	se select one)	_	Is pressure over the woun		☐ Yes	□ N ₄
□ PRESSURE ULCER □ Stage III ■ Stage IV			RGICAL	a being reneved.		
1. Is the patient being turned/positioned?	Yes			created and not represented		
2. Has a group 2 or 3 surface been used for			by descriptions above?		☐ Yes	□ No
ulcer located on the posterior trunk or pelvis?	Yes 🗌	No 2.	Description of the surgical	procedure:		
3. Are moisture and/or incontinence being managed	l? Yes					
4. Is pressure ulcer greater than 30 days?	Yes 🗌	No 3.	Date of surgical procedure	involving wound:/_	/	
☐ DIABETIC ULCER/NEUROPATHIC ULCER				cribe):	6 6	
Has a reduction of pressure on the foot ulcer		.				
been accomplished with appropriate modalities?	Yes 🗌		complete if applicable:	!	□ v	■ N.
VENOUS STASIS ULCER/VENOUS INSUFFICIENC			and a direct result of an a	ccident?	☐ Yes	IN
1. Are compression bandages and/or garments being consistently applied?	☐ Yes ☐		complete the following: of Accident:/	,		
			ent type: Auto Em			
2. Is elevation/ambulation being encouraged?	Yes	No Accid	ent type:	pioyment Irauma		
5c Wound(s) description						
	ge (Months): <u>3</u>		/ound #2 Type:	As	ge (Months):	
Wound Location: Sacrum			/ound Location:			
Is there eschar tissue present in the wound?	Yes		there eschar tissue prese		Yes	
Was debridement attempted in the last 10 days?	Yes SHARP	-	/as debridement attempte		☐ Yes	∐ N∈
f yes, debridement date: 1 /1 /23 /23			•	/T		-
Are serial debridements required?	☐ Yes	- ^	re serial debridements rec		☐ Yes	
Measurement Date: 1 /1 /23 Length: 4 cm Depth: 9			leasurement Date:			
Appearance of wound bed and color: Beefy Red	cm		-	th:cm Depth:	cm	
Exudate (amount and color): Moderate				and color:		
Is the wound full thickness?	Yes	7.61	xudate (amount and color	\$600		
Is muscle, tendon or bone exposed?	Yes	NI- 10	the wound full thickness		Yes	
Is there undermining?	☐ Yes	l '°	muscle, tendon or bone	exposed?	☐ Yes	
Location #1: cm, from to o'clock	_ 100	- "	there undermining?	.m to =====1-	☐ Yes	
Location #2: cm, from to o'clock				m to o'clock		
Is there tunneling/sinus?	☐ Yes ■		there tunneling/sinus?	to o clock	Yes	□ м.
			cation #1:cm, at		☐ tes	□ 140
Location #1: 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.



Web

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1-800-228-3957 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.

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