



Please fax this form to KCI at **1-888-245-2295**.

Refer to manufacturer's instructions for use and V.A.C.® Therapy Clinical Guidelines for guidance on therapy application.
Information requested is required by Medicare, Medicaid and/or private insurance.

1 Patient/Prescriber Information (Complete in Full or Fax Written Prescription)

(Prescriber must sign and date. No stamps. This form is only to be used if you will not be providing a separate written order.)

Patient Name (*print*) Last: _____ First: _____ MI: _____

Patient D.O.B: ____/____/____ Patient HIC/ID#: _____

I prescribe KCI V.A.C.® Therapy and up to 15 V.A.C.® Therapy dressings per wound and up to 10 V.A.C.® Therapy canisters per month up to:

1 Month 2 Months 3 Months 4 Months Other numeric value: _____

Starting date of therapy: ____/____/____ (If starting therapy is blank, use my signature date as start of therapy)

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

If referring physician, list Name: _____ Phone: _____

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

Address: _____ City: _____ ST: _____ Zip: _____

Prescriber Phone: _____ Fax: _____ NPI: _____

Prescriber Only to Complete. Original Signature Required. No Stamps.

Prescriber's Signature: _____ Date: ____/____/____

By signing and dating, I attest that I am prescribing the KCI V.A.C.® 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.® product as well as the KCI V.A.C.® Therapy Clinical Guidelines. I also understand the KCI V.A.C.® Therapy System contraindications: Patients with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistulas, necrotic tissue with eschar present, sensitivity to silver (V.A.C. GranuFoam Silver® Dressing only). Foam dressings for the V.A.C.® Therapy System should not be placed directly in contact with exposed blood vessels, anastomotic sites, organs, or nerves.

2 Supplies for Delivery* Please CHECK the KCI V.A.C.® Therapy Dressing Types Requested.

Does patient require V.A.C.® Therapy Dressings? Yes No **If "Yes", please complete below.**

<input type="checkbox"/> V.A.C.® Simplace™ <i>Dressing Kits contain V.A.C.® GranuFoam™ Dressing(s), V.A.C.® Drape(s) and SensaT.R.A.C.™ Pad</i>	Dressing Kit: <input type="checkbox"/> Small <input type="checkbox"/> Medium
<input type="checkbox"/> V.A.C.® GranuFoam™ Bridge <i>Dressing Kits contain one V.A.C.® GranuFoam™ Dressing, pre-built bridge and V.A.C.® Drape</i>	Dressing Kit: V.A.C.® GranuFoam™ Bridge
<input type="checkbox"/> V.A.C.® GranuFoam™ <i>Dressing Kits contain one V.A.C.® GranuFoam™ Dressing, V.A.C.® Drape and SensaT.R.A.C.™ Pad</i>	Dressing Kit: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large Dressing: <input type="checkbox"/> Heel <input type="checkbox"/> Thin <input type="checkbox"/> Round <input type="checkbox"/> Other _____
<input type="checkbox"/> V.A.C.® WhiteFoam <i>Dressing Kits contain one V.A.C.® WhiteFoam Dressing, V.A.C.® Drape and SensaT.R.A.C.™ Pad</i>	Dressing Kit: <input type="checkbox"/> Small <input type="checkbox"/> Large Dressing: <input type="checkbox"/> Small (foam only) <input type="checkbox"/> Large (foam only)
<input type="checkbox"/> "Y" Connectors	<input type="checkbox"/> Other _____

V.A.C.® GranuFoam™ is a black polyurethane foam often used to assist granulation and exudate removal. V.A.C.® WhiteFoam is a polyvinyl foam often used in tunnels, undermining and on grafts.



V.A.C.® Therapy Insurance Authorization Form v.2

Please fax this form to KCI at **1-888-245-2295**.



Patient Name: _____ D.O.B.: ____/____/____

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3 Requestor, Clinical Provider and Product Delivery Information (Must be Completed in Full)

REQUESTOR FACILITY INFORMATION

Name: _____ Title: _____

Facility Name: _____ Facility NPI: _____

Address: _____

City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____

Preferred Communication Method: Phone Fax Email _____

The KCI V.A.C.® System will be used in what type of facility: Private Residence WCC SNF/LTAC Rehab
 Assisted Living Group Home Custodial Care Other: _____

CLINICAL PROVIDER INFORMATION

Requestor is same as Clinical Provider Clinical Provider not known at this time (please forward information as soon as possible)

Name of Clinical Provider Providing Dressing Changes: _____ Address: _____

City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____

PRODUCT DELIVERY ADDRESS (Select delivery location below. Deliveries cannot be made to a P.O. Box)

Patient Home Facility Name: _____ Other: _____

Delivery Address: Same as Patient Address Same as Requestor Address Other Address: _____

City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____

Contact Name at this Address: _____ Title: _____

Location Where Therapy Administered: Patient Home Facility Other Address: _____

City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____

4 Patient Information (Complete in Full or Fax Patient Face Sheet)

Patient's Permanent Address: _____

City: _____ ST: _____ Zip: _____ Phone: _____

Family Contact: _____ Phone: _____

Is the patient's wound a direct result of an accident? Yes No Date of accident: ____/____/____

Accident Type: Auto Employment Trauma Responsible Party: _____

INSURANCE INFORMATION: COMPLETE ONLY if you will not be faxing this information separately (Patient Face Sheet).

Primary Insurance: Medicare Insurance Medicaid HIC/ID#: _____

Primary Insured (Subscriber) Name: _____ Subscriber Relationship to Patient: _____

Subscriber D.O.B.: ____/____/____ Insurance Phone: _____

Insurance Name: _____ Address: _____

Policy #: _____ Group Name: _____ Group #: _____

Secondary Insurance: Medicare Insurance Medicaid HIC/ID#: _____

Secondary Insured (Subscriber) Name: _____ Subscriber Relationship to Patient: _____

Subscriber D.O.B.: ____/____/____ Insurance Phone: _____

Insurance Name: _____ Address: _____

Policy #: _____ Group Name: _____ Group #: _____



KCI Customer Service:
1-800-275-4524

V.A.C.® Therapy Insurance Authorization Form v.2

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Patient Name: _____ D.O.B.: ____/____/____

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5 Clinical Information by Wound Type (Complete in Full. Insurance Coverage may Require Additional Documentation)

PATIENT'S WOUND HISTORY

- Was Negative Pressure Wound Therapy (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: _____
- Is the patient's nutritional status compromised? Yes No Facility City, ST: _____
 If yes, check the action taken: Protein Supplements Enteral/NG Feeding TPN Vitamin Therapy Special Diet
- Indicate other therapies that have been previously tried and failed to maintain a moist wound environment.
 Saline/Gauze Hydrogel Alginate Hydrocolloid Absorptive None Other: _____
- If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying NPWT with V.A.C.® Therapy in inpatient or home health?:
 Presence of co-morbidities High risk of infection Need for accelerated granulation tissue
 Prior history of delayed wound healing Other, please describe: _____
- Is the patient a diabetic? Yes No Is the patient on a comprehensive diabetic management program? Yes No
- Describe the co-morbidities or complicating factors which impair wound healing for this patient and possible consequences if V.A.C.® is not used (complicating factors not impacting wound healing do not need to be provided):

PATIENT'S PRIMARY WOUND TYPE

- TRAUMATIC:** Orthopedic Soft Tissue/Open Wound Traumatic Amputation
- SURGICAL:** Surgical (non-dehiscid) Dehiscid (disrupted) Flap Pre-op Necrotizing Fasciitis
 Date of Surgery: ____/____/____ Graft Post-op
 Other (please describe) _____

- PRESSURE ULCER:** Stage III Stage IV (If No, please explain.)
- Is the patient being turned/positioned? Yes No _____
 - Has a Group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? Yes No _____
 - Are moisture and/or incontinence being managed? Yes No _____
 - Is pressure ulcer greater than 30 days? Yes No _____
- DIABETIC ULCER:**
 1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? Yes No _____
- 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 _____
- BURNS** (Not currently covered by Medicare)
- OTHER** (explain) _____

Patient Name: _____ D.O.B.: ____/____/____

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5 Clinical Information by Wound Type (Complete in Full. Insurance Coverage may Require Additional Documentation)

WOUND MEASUREMENTS

Wound #1 Type: _____ Wound Age in Months: _____
 Is there less than 20% slough/fibrin in the wound? Yes No
 Has debridement been attempted in the last 10 days? Yes No
 If Yes, debridement date: _____ Debridement type: _____
 Are serial debridements required? Yes No
 Measurement Date: ____/____/____ Wound Location: _____
 Length: _____ cm Width: _____ cm Depth: _____ cm
 Is this 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 @ _____ o'clock
 Location #2: _____ cm @ _____ o'clock
 Appearance of wound bed and odor: _____
 Exudate (amount and color): _____

Wound #2 Type: _____ Wound Age in Months: _____
 Is there less than 20% slough/fibrin in the wound? Yes No
 Has debridement been attempted in the last 10 days? Yes No
 If Yes, debridement date: _____ Debridement type: _____
 Are serial debridements required? Yes No
 Measurement Date: ____/____/____ Wound Location: _____
 Length: _____ cm Width: _____ cm Depth: _____ cm
 Is this 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 @ _____ o'clock
 Location #2: _____ cm @ _____ o'clock
 Appearance of wound bed and odor: _____
 Exudate (amount and color): _____