



# DWO for Compression

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER: \_\_\_\_\_

DATE OF LAST FACE TO FACE: \_\_\_\_\_

## PATIENT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

## REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name \_\_\_\_\_ Therapist Name \_\_\_\_\_

Clinic Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Therapist Email \_\_\_\_\_

## PRODUCT PRESCRIBED

### SELECT ONE:

### RECORD # OF PAIRS/REFILLS:

### MUST SPECIFY:

Ready to Wear

Qty Per Body Part

3

# of Refills

Right

Left

Bilateral

Custom

Qty Per Body Part

3

# of Refills

Right

Left

Bilateral

### DAYTIME AND/OR NIGHTTIME:

Daytime

Nighttime

Both

### GRADIENT COMPRESSION LEVEL:

20-30 mmHg

30-40mmHg

50+mmHg

Custom \_\_\_\_\_

### BODY PART (check all that could apply):

Lower Leg/Foot (Knee High)

Upper Leg/Foot (Thigh High)

Full Leg/Foot (Waist High)

Ankle

Foot

Toe Caps

Arm Sleeve

Gauntlet

Glove

Neck/Head

Torso

Shoulder

Open Toe

Full Foot

Silicone Band

Narrative: \_\_\_\_\_

## DIAGNOSIS

Primary ICD10 Numeric Code: \_\_\_\_\_

Secondary ICD10 Numeric Code: \_\_\_\_\_

## PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing compression garments as medical necessary and all other related treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use.

Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date Signed \_\_\_\_\_



## **We cannot service your patient without the following completed.**

**Detailed Written Order (DWO)** signed by the patient's physician. Must include the following:

- 3 Dates: Date of Order, Face to Face Date and Physician's Signature Date
- Patient Information
- Product prescribed per body part, check all that apply
- Right, Left or Bilateral for all pieces being prescribed
- If the patient has Lymphedema, one of the following diagnoses must be referenced in the medical notes:
  - I89.0 Lymphedema, not elsewhere classified
  - I97.2 Postmastectomy lymphedema syndrome
  - I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
  - Q82.0 Hereditary lymphedema

**Demographic Sheet** with insurance information.

**Medical notes** MUST detail the following:

- One of the diagnosis's listed above
- If you are treating the patient with a custom garment, the medical records must necessitate the use of a custom fitted gradient compression garment versus an off-the-shelf standard gradient compression garment.
- Explanation of the patient's current condition and that they would benefit from the specific garment(s) being ordered.

**MedCOR will follow up with patients to discuss financial responsibility and next steps.**

- MedCOR verifies patient insurance eligibility and contacts the patient directly to discuss financial responsibility.
- MedCOR schedules an appointment for patients to be measured and fitted, if needed.
- MedCOR services patients with appropriate garments. If a special order is needed, MedCOR will order garments and direct ship.

### **Please note:**

MedCOR is bound by strict regulations and guidelines for insurance services. We might have to call clinic referral sources and/or doctor's offices several times to get all accurate information on file in order to service your patient. This is due to strict Medicare regulations which are followed by most insurance carriers.