**Negative Pressure Wound Therapy Request Form**

**(Review must come from physician or their designee – office or hospital staff – and called into MPRO, no faxes accepted. Please supply as much information as possible.)**

BENEFICIARY Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Ordering Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician NPI# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (only 2 weeks can be authorized at a time)

DME Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DME NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DME Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DME Fax # \_\_\_\_\_\_\_\_\_\_

How many times a week will the dressings be changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis/patient’s history (must be related to the need for negative pressure wound therapy and wound healing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Wound location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wound dimensions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ stage of wound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the wound free of necrotic tissue? YES NO \*\*(Wound measurements must be less than 7 days old.)

Other dressings that have been tried (not including debridement)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient had a nutritional evaluation? YES NO Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serum protein: \_\_\_\_\_\_\_\_\_ Serum albumin: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

For Stage III or IV Pressure Ulcers: Patient must be part of a comprehensive ulcer management plan:

* Has the patient been appropriately turned and repositioned? YES NO
* How has the patient’s moisture/incontinence been managed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has the patient been on an ulcer management plan for at least 30 days? YES NO
* Mattress type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetic Ulcers: Is the patient on a comprehensive diabetic management program? YES NO

Venous Stasis Ulcers:

* Is the patient wearing compression bandages? YES NO
* Has mobility and leg elevation been encouraged? YES NO

Dehisced incisions/traumatic wounds: wound care clinical protocols must have been ineffective.

\*\*Please be aware that Negative Pressure Wound Therapy is covered for short-term therapy (7-14 days). If a longer treatment period is required, additional reviews will need to be performed and documentation of current wound status needs to be provided to substantiate continued effectiveness of treatment.

\*\*The information above is not all inclusive, additional information may be required at the time of the telephonic review.

\*\*\*For additional information please access the Medical Supplier Chapter of the Medicaid Provider Manual: <http://www.michigan.gov/mdch>