CONFIRMATION OF ORDER — Wound Care

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: _____ **Date of Birth:** _____

Order Date: _____ **Insurance:** _____

Length of Need: _____

Physician: _____ **NPI:** _____

DIAGNOSIS

ICD 10 Code	Description

PRESCRIPTION INFORMATION

Each wound must be sized & documented or insurance will deny:

Wound #1: Size in inches _____ Location of wound _____

Wound #2: Size in inches _____ Location of wound _____

Wound #3: Size in inches _____ Location of wound _____

Wound #4: Size in inches _____ Location of wound _____

Wound Treatment:

# of Changes per Day _____ # Treatment Days _____

Directions for use _____

Necessary Products:

Product 1: _____ Qty _____

Product 2: _____ Qty _____

Product 3: _____ Qty _____

Product 4: _____ Qty _____

Product 5: _____ Qty _____

☐ May Substitute or ☐ May Not Substitute

Refills: _____

Physician Signature: _____ **Date:** _____