



Byram Fax Form - Lance Ellis

Referral # 777777

Customer Service (800) 334-0235 x 33960

Fax 281-220-6448

Lance Cell: 281-917-7674

Patient

Re-order Face Sheet Attached

Order Date of

Name (L) (F)

Ordered by

DOB / /

Is the patient being seen by a home health agency? Yes No

Diabetes? Yes No None

Dr. Last Dr. First ID #

Signature X Date

By signing this form, I confirm the physician signature corresponds to the name and NPI detailed above and that I am prescribing the items and quantities listed below.



Signature X

Date

Duration of Need: 3 months unless indicated otherwise

Other: (mths)

Wound

Table with columns: Location, Type or ICD.9 code, Dimensions (cm's) (Length, Width, Depth), Drainage (Dry, Lt, Mod, Hvy), Thickness (Part, Full)

Only need on new orders or when plan of care changes

Drainage

Dry Light Mod Heavy

One dressing per change unless otherwise noted



Days Supply

15 30

Change Frequency, ie, QD

Table with columns: 30-Day Allow Amt, Wnd #1, Wnd #2, Wnd #3, Wnd #4

Full Thickness Brand/Size (circle)

Table listing products: Alginate, Gauze Non Sterile, Gauze Sterile, Bandage, Self-Adh, ABD Pad, Sterile, Conform Band., St., Roll Gauze, St., Unna Boot

No-Charge Ancillary Items

Sterile Gauze, Unit Dose Saline and NS Gloves

Check to Order

Other (Refer to Available Dressing List)

Tape Paper Waterproof Silk 1" 2" Hypafix 2" 4" Qty (rolls):

Patient Authorization of Release of Information and Assignment of Benefits - My signature on the line below authorizes any of the following. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the Social Security Act) and/or any other Medical Insurance is correct. I authorize the release to Byram Healthcare any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Byram Healthcare on assigned claims. I authorize Byram Healthcare to submit claims to Medicare and/or any other Medical Insurance carrier. I agree to assume responsibility for any balances for supplies furnished to me by Byram Healthcare not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance and non-covered items. I authorize that photo copies shall be valid as originals.



Patient Signature (Initial order only) X

Date

Pt. email:

Verson 10/05/2012