CATH DRY GLOBAL (CDG)

CENTRAL VENOUS CATHETER DRESSING

760-478-3747 orders@cathdryglobal.com 818-491-7682 FAX

ORDER FORM

Please email or fax the completed form to process your patient's order

PATIENT INFORMATION

Name: ______ Order Start Date: ______

Email: ______ Phone: ______ Date of Birth: ______

Shipping Address: ______

City: ______ State: ______ Zip Code: ______

INSURANCE INFORMATION

☐ Medicare ID# ______

☐ Primary Insurance Name: ______

Member ID# ______

Medical Necessity

- Preventing Catheter Related Infections
- Improved Quality of Life – Ability to Safely Shower (Personal Hygiene)

PRODUCTS

CATHETER DRESSING	ICD. 10 Codes: Z45.2 and Z48.01	
☐ **Cath Dry HD (Hemodialysis)** HCPCS Code(s) - A6259 and A5200 Quantity - 12 Dressings Dressing Change - 3x/Week	☐ **Cath Dry XL** **(Extra Long HD Catheters - i.e Tesio)** HCPCS Code(s) - A6259 and A5200 Quantity - 12 Dressings Dressing Change - 3x/Week	• Primary Surgical Dressing • Sterile • Water Resistant • Breathable • Transparent • Bacteriostatic • Water/Moisture Indicator
☐ **Cath Dry PICC** **(Peripherally Inserted Central Catheter)** HCPCS Code(s) - A5200 and A4221 Quantity - 4 Dressings + 4 Securement Devices Dressing Change - 1x/Week	☐ **Cath Dry PD** **(Peritoneal Dialysis/Hickman Catheters)** HCPCS Code(s) - A6259 and A5200 Quantity - 4 Dressings + 4 Securement Devices Dressing Change - 1x/Week	

REFILLS: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 **DISPENSING FREQUENCY:** ☐ Every 30 Days

INDICATIONS: ☐ Hemodialysis ☐ Chemotherapy ☐ Antibiotics ☐ TPN (Total Parenteral Nutrition)

☐ Chronic Illness ☐ Other: ______

AUTHORIZATION AND SIGNATURE

Providers Name: ______

NPI#: ______

License #: ______

Office Phone#: ______

Provider Address: ______

______

City: ______

State: ______ Zip Code: ______

COORDINATION OF CARE

I ATTEST THAT I AM A PROVIDER/CLINICIAN PROVIDING NECESSARY HEALTH CARE TO THE ASSOCIATED PATIENT WHO REQUIRES COORDINATION OF CARE AND CDG HAS THE AUTHORITY TO COORDINATE CARE ON BEHALF OF MY PATIENT. FURTHERMORE THE PATIENT HAS CHOSEN CDG TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FOR SERVICE OR COORDINATING CARE FOR THE ASSOCIATED PATIENT SHOULD DIRECT SERVICE NOT BE AN OPTION.

PROVIDER/CLINICIAN COORDINATING CARE:

______ (PRINT NAME}

PROVIDER SIGNATURE: ______

DATE: ______