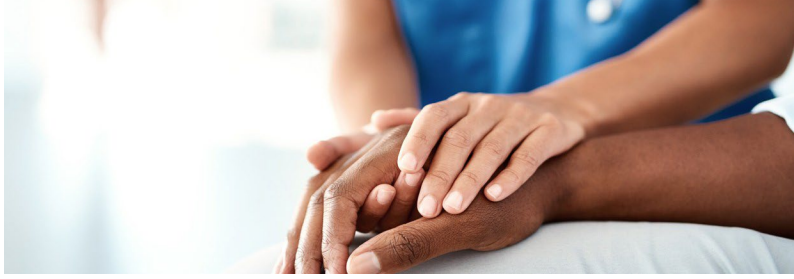
Woundtech



Patient Referral Form

Please ensure the following information is included on the referral form:

- Eligible insurance for the patient
- Authorization number
- Patient contact information and address
- Caregiver/Family member contact information
- PCP information
- Medical records
- Copy of insurance card
- Place of service
- Number of visits

How to Submit a Referral

1. Upload or fax a referral to Woundtech, including authorization (if required).
2. Upload referral to Woundtech Referral Portal including authorization, patient demographics, and all supporting clinical documentation.

866.968.6339
866.986.2263
INTAKE@WOUNDTECH.NET
HTTPS://REGUSA.WOUNDTECH.NET

Portal login

Be sure to visit our referral page on our website Referrals (woundtech.net) and save the landing page to your favorites bar on your web browser.

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PATIENT REFERRAL FORM

ATTENTION: CASE MANAGERS, DISCHARGE PLANNERS, REFERRAL COORDINATORS AND UTILIZATION MANAGERS

ALL ITEMS MARKED WITH (*) ARE REQUIRED.

REFERRING PROVIDER INFORMATION*

PERSON COMPLETING THIS FORM: NAME: _____ PHONE#: _____

PATIENT AWARE OF REFERRAL TO WOUNDTECH? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____ FAX #: _____

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY): _____

REFERRING FACILITY NAME: _____

REFERRING FACILITY PHONE #: _____ REFERRING FACILITY E-MAIL ADDRESS: _____

IPA/MSO (IF APPLICABLE): _____

PATIENT INFORMATION

IS THE PATIENT'S PCP AWARE THAT WOUNDTECH WILL BE CONTACTING THE PATIENT FOR TREATMENT? ☐ YES ☐ NO

PATIENT NAME: _____ D.O.B.: _____

PATIENT ADDRESS*: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT PHONE*: _____ PATIENT EMAIL: _____

CAREGIVER/FAMILY PHONE*: _____ CAREGIVER/FAMILY EMAIL*: _____

CURRENT LOCATION OF PATIENT: _____

PATIENT LOCATION: ☐ SNF/ALF ☐ HOME NUMBER OF VISITS*: ☐ 2 ☐ 8 ☐ 12

PATIENT SKILLED AUTHORIZATION # (IF PART A): _____

ELIGIBLE INSURANCE INFORMATION*

DATE OF REFERRAL: _____ AUTHORIZATION NUMBER*: _____

NAME OF HEALTH PLAN: _____ PLAN TYPE: _____

MEMBER ID: _____

REASON FOR REFERRAL

CPT CODE*: _____ WOUND LOCATION: _____

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS

☐ OTHER: _____

REFERRALS FROM PCP: include patient facesheet/demographics and pertinent medical records

REFERRALS FROM SNF: include patient facesheet/demographics, patient skilled authorization number (if Part A), physician order and pertinent medical records