Dear Provider,
Your patient, _____would like to receive services at the Comprehensive Wound Care Center. The insurance provider _____, requires a prior authorization submitted by the primary care physician before he can be scheduled to receive services.

Please submit a prior authorization request for the following services:

CPT Codes:
G0463 – Evaluation and management
97597 – Selective debridement
11042 – Excisional debridement subcutaneous
11043 – Excisional debridement muscle
11044 – Excisional debridement bone
97602 – Nonselective debridement
29445 – Total contact cast
29580 – Unna boot
29581 – Multilayer compression wrap
17250 – Chemical cauterization
10060 – I&D abscess

The facility tax id: 581966795
2701 N. Decatur Rd.
Decatur, GA 30033

Location code: 22 or On Campus Outpatient Hospital Facility

Physician NPI:

Physician name:

Number of visits:

If we can be of assistance, feel free to call our office.
We look forward to serving your patient.

Ashia Searcy

Front Office Coordinator
Comprehensive Wound Center
ph: 404-501-7455
fax: 404-501-7441

EMORY HEALTHCARE

PS-1248

REFERRAL FORM

DMC FORM # PS-1248 (03/20/18)

Patient Information (Required for Scheduling)

Patient Name:_____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX- _____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Wound Care Center

Diagnosis: _____ ICD-CM Diagnosis Code: _____

Reason for Referral:

❑ Wound Care Evaluation and Treatment
❑ Wound Care Evaluation and Treatment (Hyperbaric Evaluation Included)
❑ Hyperbaric Evaluation & Treatment Only

Please check all that apply: ***(H) denotes Hyperbaric Treatment Candidate***

❑ Acute Peripheral Arterial Insufficiency (H)
❑ Acute Traumatic Peripheral Ischemia
❑ Actinomycosis (H)
❑ Arterial Ulcer
❑ Cellulitis
❑ Wound Dehiscense
❑ Decubitus Ulcer
❑ Diabetic Wound Lower Extremity (H)
❑ Compromised or Failed Flap Graft (H)
❑ Necrotizing Infection (H)
❑ Osteoradionecrosis (H)
❑ Hemorraghic Cystitis
❑ Peripheral Vascular Disease
❑ Post Operative Wound
❑ Osteomyelitis (H)
❑ Radiation Proctitis (H)
❑ Soft Tissue Radionecrosis (H)
❑ Radiation Injury – Other (H)
❑ Trauma
❑ Venous Stasis
❑ Thermal Burn
❑ Other:

Auth Ref# _____

I herby certify that the services below, as indicated by the CPT Codes provided, are medically necessary.

CPT Codes:

G0463-Evaluation and management	97597-Selective debridement	97602-Nonselective debridement
110442-Excisional debridement subcutaneous	110443-Excisional debridement muscle	110444-Excisional debridement bone
29445-Total contact cast	29580-Unna boot	29581-Multilayer compression wrap
17250-Chemical cauterization	10060-I&D Abscess	

Physician Panel

Rick Boden, M.D., Medical Director

Robin Dretler, M.D. Adam Bressler, M.D. Hieu Nguyen, M.D. Anson Wurapa, M.D.

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #: _____

Physician Signature: _____ Date: _____ Time: _____

EMORY HEALTHCARE

FAX Orders to: 404.501.7441
Phone: 404.501.7455

P S - 1 0 6 0

WOUND CARE CENTER ORDER FORM

DMC FORM # PS-1060 (02/12/18)