Patient Insurance Information
PleurX® Drainage Kits

CareFusion

Patient Information: Complete the following section or **attach the patient's face sheet.**

Patient Name: Last _____ First _____ M.I. _____

Patient Phone: _____

Alternate Contact Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance Information:

Complete insurance information is critical for timely shipment of supplies

Primary Insurance: _____ Phone: _____

Policyholder: _____ ID #: _____

Employer or Group Name: _____ Group #: _____

Secondary Insurance: _____ Phone: _____

Policyholder: _____ ID #: _____ Group #: _____

Hospital Information:

Hospital: _____

Placement Date: _____ Discharge Date: _____

Name of PleurX Contact at Physician's Office: _____

Name of Referring Physician: _____

Patient Care: Complete this section. If applicable, may reduce patient's supply cost.

Patient is being discharged to:

- ☐ Home with no nurse in home
- ☐ Nurse in home (HHA/VNA)
- ☐ Hospice
- ☐ Skilled Nursing Facility (SNF)

Vacuum Bottle Size:

- ☐ 1000 ml
- ☐ 500 ml

Number of bottles discharged with: _____

Care Start Date: _____ Name of Provider: _____

Provider Contact: _____ Phone: _____

Please fax completed forms to: 877.307.6350

☐ I would like confirmation the prescription was received.

Contact me via ☐ Phone: _____ or ☐ E-Mail: _____

Preserve original order or mail to:

Edgepark Medical Supplies
1810 Summit Commerce Park
Twinsburg, OH 44087

Questions? Call the PleurX specialists: 877.307.8033

Notes: _____

This prescription or the information contained herein may be shared with or reported to CareFusion, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients using the PleurX product line. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with CareFusion, please call 877-307-8033 and a PleurX Specialist at Edgepark Medical Supplies will assist with this request and ensure that the information is not shared.

CareFusion or authorized representative (Edgepark Medical Supplies)

Detailed Written Order
PleurX® Drainage Kits

CareFusion

Section A:

Patient Name: _____ D.O.B.: _____ Sex: ☐ M ☐ F

Phone: _____ Patient Address: _____

City: _____ State: _____ ZIP: _____

Physician: _____ Phone: _____

Physician Address: _____

City: _____ State: _____ ZIP: _____

Place of Service: Home

Section B: Please Review and/or Complete

Primary Diagnosis — Location of Fluid Accumulation (required)

Diagnosis (ICD-9) Please Check Appropriate Diagnosis:

☐ **511.9 Unspecified Pleural Effusion** ☐ **789.51 Malignant Ascites** **Other:** _____

☐ **511.81 Malignant Pleural Effusion** ☐ **789.59 Other Ascites** **Other:** _____

Secondary Diagnosis — Condition Causing Drainage Treatment (required)

For Example: Diagnosis (ICD-9) 197.0 Lung Cancer, 174.9 Breast Cancer, 183.0 Ovarian Cancer or 428.0 CHF

_____ _____ _____

Length of Need (Months): _____ 1 – 99 (99 = Lifetime)

Use Y for Yes, N for No or D for Does Not Apply unless otherwise noted.

_____ 1. The catheter was placed for refractive pleural effusion and requires drainage.

_____ 2. The catheter was placed for recurrent ascites and requires drainage.

Please indicate the prescribed patient drainage requirements.

Single Drain

☐ Once per day (90 PleurX Drainage Kits in 90 days)

☐ Every other day (45 PleurX Drainage Kits in 90 days)

☐ Other (_____ number PleurX Drainage Kits in 90 days)

Bilateral Drain

☐ Once per day (180 PleurX Drainage Kits in 90 days)

☐ Every other day (90 PleurX Drainage Kits in 90 days)

☐ Other (_____ number PleurX Drainage Kits in 90 days)

Note: Each case contains 10 PleurX Drainage Kits. Each drainage kit contains: vacuum bottle with drainage line, foam pad with cut for catheter, transparent dressing, alcohol wipes (qty. 3), 4˝ x 4˝ gauze pads (qty. 4), surgical drape, gloves, clamp and replacement valve cap.

Section C: Physician Attestation

I certify that I am the physician identified on this form. I have reviewed all sections of the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and Physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical records.

Please Sign Here → Prescriber's Signature _____

Signature Stamps and Date Stamps Are Not Acceptable

Date _____/_____/_____ **UPIN:** _____ (if appropriate) **NPI #:** _____

Fax completed forms to 877.307.6350

Note that incomplete or incorrect forms may experience a delay in processing.

CareFusion or authorized representative (Edgepark Medical Supplies)