Detailed Written Order

ASEPT® Drainage Kits

HAR-KEL, INC.
Medical Specialties
1903 Mayview Road
Bridgeville, PA 15017
Phone: 1.800.257.1830
Fax: 1.800.257.1840

Section A:

Patient Name: _____ D.O.B._____ Sex: ☐ Male ☐ Female

Phone: _____ Patient Address: _____

City: _____ State: _____ Zip: _____

Physician _____ Phone: _____ Fax: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Place of Service: Home DOS: _____

Section B:

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 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, 428.0 CHF

Diagnosis Diagnosis Diagnosis

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

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's drainage requirements.

Single Drain

☐ Once per day (30 ASEPT Drainage Kits in 30 days)

☐ Every Other Day (15 ASEPT Drainage Kits in 30 days)

☐ Other (_____ ASEPT Drainage Kits in 30 days)
number

Bilateral Drain

☐ Once per day (60 ASEPT Drainage Kits in 30 days)

☐ Every other day (30 ASEPT Drainage Kits in 30 days)

☐ Other (_____ ASEPT Drainage Kits in 30 days)
number

Note: Each case contains 10 ASEPT Drainage Kits. Each drainage kit contains: vacuum bottle with drainage line, Split Foam Dressing, transparent dressing, alcohol wipes (qty. 3) 4 x 4 gauze (qty. 4), gloves, clamp.

Section C: Physician Attestation

I certify that I am the physician on this form. I have reviewed all 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 Har-Kel, Inc. upon request. I understand any falsification, omission, or concealment of material face 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 record.

Please Sign Here Prescriber's Signature _____
Signature Stamps and Date are not Acceptable

Date ____/ _____/ _____ MD:_____ NPI: _____

***** Please Fax Completed Forms to: 1-800-257-1840*****

Patient Insurance Information

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Patient Information: Please, complete the following section or attach the patient's face sheet.

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

Patient Phone: _____

Alternate Contact Person: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Insurance Information:

***** Complete Insurance Information is Critical for Timely Shipment of Supplies*****

Primary Insurance: _____ Phone: _____

Policy Holder: _____ ID #: _____

Employer or Group Name: _____ Group # _____

Secondary Insurance: _____ Phone: _____

Policy Holder: _____ ID # _____

Hospital Information:

Hospital: _____

Placement Date: _____ Discharge Date: _____

Name of the ASEPT 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
- ☐ Home with a nurse in home
- ☐ Hospice
- ☐ Skilled Nursing Facility

Vacuum Bottle Size:

- ☐ 1000 ml
- ☐ 600 ml

Number of bottles discharged with: _____

Care Start Date: _____ Name of Provider: _____

Provider Contact: _____ Phone: _____

☐ ASEPT 2000 ml bag Drainage Kits

***** Please Fax Completed Forms to: 1-800-257-1840*****

If you would like confirmation that this order was received, please fill out information below:

Phone: _____ or E-Mail: _____

Preserve Original Order or Mail to:

Har-Kel, Inc.
1903 Mayview Road
Bridgeville, Pa 15017

Notes: _____

***** Please Fax Completed Forms to: 1-800-257-1840*****