Dear Provider,
Your patient, ____________________________ would like to receive services at the DeKalb Medical 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:

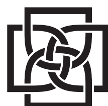
Physician name:

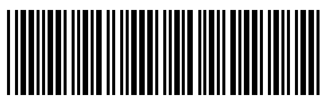
Number of visits:

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

Ashia Searcy

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


DeKalb Medical



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)
❑ Arterial Ulcer
❑ Decubitus Ulcer
❑ Necrotizing Infection (H)
❑ Peripheral Vascular Disease
❑ Radiation Proctitis (H)
❑ Trauma
❑ Other:

❑ Acute Traumatic Peripheral Ischemia
❑ Cellulitis
❑ Diabetic Wound Lower Extremity (H)
❑ Osteoradionecrosis (H)
❑ Post Operative Wound
❑ Soft Tissue Radionecrosis (H)
❑ Venous Stasis

❑ Actinomycosis (H)
❑ Wound Dehiscense
❑ Compromised or Failed Flap Graft (H)
❑ Hemorraghic Cystitis
❑ Osteomyelitis (H)
❑ Radiation Injury – Other (H)
❑ Thermal Burn

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
110442-Excisional debridement subcutaneous
29445-Total contact cast
17250-Chemical cauterization

97597-Selective debridement
110443-Excisional debridement muscle
29580-Unna boot
10060-I&D Abscess

97602-Nonselective debridement
110444-Excisional debridement bone
29581-Multilayer compression wrap

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

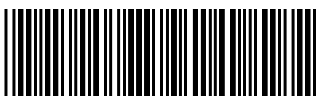
Physician Name (first & last): ________________________________ NPI#: __________________ GA License#: _______________________

Physician Address: ____ Phone#: ____________________ Fax #: _________________________

Physician Signature: ____ Date: ____________ Time: ____________

DeKalb Medical

FAX Orders to: 404.501.7441
Phone: 404.501.7455



WOUND CARE CENTER ORDER FORM

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