1. Physician Enrollment and Credentialing Packet

National Wound Care Program – Physician Enrollment Form

Practice Name: _____
Physician Name: _____
NPI Number: _____
License Number & State: _____
Specialty: _____
Board Certification: ☐ Yes ☐ No (If yes, provide board name and date)
Email: _____
Phone: _____
Clinic Address: _____

Training & Credentials in Wound Care (Check all that apply):
☐ Advanced Wound Care Certification
☐ Sharp Debridement Training
☐ Skin Substitute Use Experience
☐ Other: _____

Malpractice Carrier & Policy #: _____
Policy Dates: From _____ To _____

Attachments Required:

- Copy of medical license
- Wound care-related training certificates
- Malpractice insurance declaration

I hereby certify that all information provided is accurate. I agree to abide by the program's policies for skin substitute usage, documentation, and compliance requirements.

Signature: _____
Date: _____

2. Prior Authorization Request Form

Advanced Skin Substitute – Prior Authorization Request

Patient Name: _____
Date of Birth: _____
Clinic Name: _____
Physician Name: _____
Requested Product: ☐ Membrane Wrap ☐ Neostim ☐ MLG Complete ☐ Activate

Q Code: _____
Date of Request: _____

Wound Type:
☐ Pressure Injury
☐ Diabetic Foot Ulcer
☐ Venous Stasis Ulcer
☐ Arterial Ulcer
☐ Non-Healing Post-Surgical
☐ Other: _____

Wound Stage (if applicable): I ☐ II ☐ III ☐ IV ☐
Wound Duration: _____ weeks

Standard Treatments Attempted:
☐ Moisture Balance
☐ Compression Therapy
☐ Offloading
☐ Infection Control
☐ Topical Dressings
☐ Debridement

Relevant Comorbidities:
☐ Diabetes Mellitus
☐ Peripheral Vascular Disease
☐ Lymphedema
☐ Venous Stasis
☐ Pressure-induced Damage

Clinical Notes Summary: Please attach any clinical documentation

Physician Signature: _____
Date: _____

3. Monthly Utilization Report Template (Excel)

Column Headers:

| Date of Service | Patient Initials | Graft Product Used | Q Code | Units Applied (cm^2) | Serial # | Physician | Outcome Notes | Waste Reported (Yes/No) |

(You can track utilization by week and add summaries at the bottom for Quarterly reporting.)

4. Patient Consent Form for Skin Substitutes

Patient Consent for Advanced Wound Care Therapy – Skin Substitutes

Patient Name: _____
Date of Birth: _____

Clinic: _____
Treating Physician: _____

I understand that I am being offered treatment using an advanced skin substitute as part of my wound care plan. The purpose of this treatment is to assist in healing my chronic wound.

I understand:

- The product may be derived from human or placental tissue
- It has been processed and sterilized to minimize risk
- My clinical team has determined that this is medically necessary
- Alternative options have been discussed
- I may ask questions and withdraw my consent at any time

I acknowledge that my insurance may not cover the full cost and that I have received information about potential out-of-pocket expenses if applicable.

Patient/Legal Guardian Signature: _____
Date: _____

Physician Signature: _____
Date: _____

5. Clinic Self-Audit Compliance Checklist

Monthly Compliance Checklist – Wound Care Program

☐ All skin substitute applications were pre-approved via PMC woundcare
☐ Graft usage tracked with serial # logged in tracking sheet
☐ Unused grafts returned per protocol
☐ Waste reported with explanation in utilization report
☐ No skin substitutes used for non-PMC members
☐ Documentation supports medical necessity
☐ Consent forms on file for all patients
☐ Clinic staff trained in inventory handling
☐ Patient wound care plans reviewed weekly
☐ Monthly utilization report submitted to PMC

Audit Completed By: _____
Date: _____
Clinic: _____

6. Clinic Onboarding Packet Cover Sheet

Clinic Onboarding Packet – National Wound Care Program

National Wound Care Program | Skin Substitutes Advanced Biologics | PMC Healthcare Network

Welcome to the PMC Advanced Wound Care Program. Your participation enables access to cutting-edge therapies such as placental-based skin substitutes under a compliance-driven framework.

Included Documents:

- ✅ Physician Enrollment & Credentialing Packet
- ✅ Prior Authorization Request Form
- ✅ Monthly Utilization Tracking Template
- ✅ Patient Consent Template
- ✅ Clinic Self-Audit Checklist
- ✅ Compliance Acknowledgment
- ✅ Inventory Tracking Log
- ✅ Standard Operating Procedures (SOP)

Please ensure all staff are familiar with:

- Graft handling and inventory procedures
- Use of serialized tracking
- Documentation and billing standards
- Return and waste protocols
- Compliance requirements

PMC Support Contact:

📧 support@pmcwoundcare.com

📞 (XXX) XXX-XXXX