


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
SUCTION MACHINE**

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>  <b>713 Northway Dr. Anchorage, AK 99508 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001</b>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  ( ) - HIC#: . <b>Patient DOB: / / Sex: (M/F)</b>
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An order was received on \_\_\_\_\_ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by: \_\_\_\_\_

**SUCTION MACHINE AND SUPPLIES:**

Date of Service: \_\_\_\_\_

Diagnosis and Code: \_\_\_\_\_

Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)

Patient Height: \_\_\_\_\_ ft. in. Weight: \_\_\_\_\_ lbs.

Equipment:

- Suction Machine, Portable (E0600)
- Supply Kit (Includes: Canister (A7000), Conductive Tubing (A7002), Inlet Tube (A7002), Inline Filter (A9900), and Connector/Elbow (A9900)) - 2 per month

Type of Suction:

- Oral (Yankauer Tip) - 2 per month
- Tracheal (Suction Catheter) Size \_\_\_\_\_  
- 90 per month
- Other \_\_\_\_\_

**MEDICAL NECESSITY INFORMATION:**

REQUIRED CRITERIA

1. Does the patient have difficulty raising and clearing secretions secondary to: Tracheostomy, Cancer, Surgery of the Throat, Dysfunction of the Swallowing Muscle and/or Unconsciousness of Obtund State?  
 Y  N

**PROVIDER CERTIFICATION:**

**I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.**

\_\_\_\_\_  
Provider's Signature Date

\_\_\_\_\_  
Provider's Name

NPI: \_\_\_\_\_ Telephone: \_\_\_\_\_