℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
TRACHEOSTOMY CARE & LARGE VOLUME NEBULIZER (AEROSOL)

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

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:_____

TRACHEOSTOMY CARE SUPPLIES:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Date of Tracheotomy: _____

Supplies:

- ☐ Trache: Size_____- 2 per month
  - ❑ Cuffed
  - ❑ UnCuffed
- ☐ Inner Cannula, Trache: Size_____- 31 per month
- ❑ ☐ Trache Mask (A7525) – 4 per month
- ❑ ☐ Trache Ties/Collar (A7526) – 31 per month
- ❑ ☐ Trache Care Kit (A4629) – 14 per month
- ❑ ☐ Passy Muir Valve (L8501) - 1 per month
- ❑ ☐ Thermovent T (A7509) - 62 per month
- ❑ ☐ Saline, 5 ML (A4216) - 1 bx per month
- ❑ ☐ Non-sterile Gauze, (A6216) - 1 pk per month ❑ ☐auze, Split, 4x4 (A6402) – 3 bx per month
- ❑ ☐ Cotton Tip Applicators, Sterile (A9999) - 1 bx per month
- ❑ ☐ Gloves (A4930) - 40 pairs per box, _____boxes
- ❑ ☐ Hydrogen Peroxide (A4244) - 3 per month
- ☐ Other_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient require replacement of the tracheostomy tube on a routine basis?
   ☐Y ☐N
   Specific Frequency:_____
2. Does patient require routine trache cleaning more than one (1) time per day?
   ☐Y ☐N
   Specific Frequency:_____

Large Volume Nebulizer (Aerosol):

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Equipment:

- ☐Large Volume Nebulizer (Aerosol) (E0565)
- ☐Heater (A9900)

Supplies:

- ☐ Water Trap, Lg Volume (A7012) – 4 per month
- ☐ Tubing, Corrugated (A7010) – 12 per month
- ☐ Nebulizer Cap, Large Volume (A7007) – 4 per month
- ☐ Sterile Water for Inhalation (A4217) – 31 per month
- ☐ Heater Barrels (A9270) – 4 per month
- ☐ Other_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient require humidity due to thick, tenacious secretions?
   ☐Y ☐N
2. Does the patient have cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent?
   ☐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: _____