℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
SUCTION MACHINE

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. 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.

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
- ☐ Suction Toothbrush Pack (A9900) – 60 per month
- ☐ Toothbrush Handle – 2 per month
- ☐ Saline Addipak 5ml (A4216) 100 per month
  Other Qty: _____

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: _____