℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
COUGH STIMULATING DEVICE

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **3519 Industrial Avenue** **Fairbanks AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - 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.

COUGH STIMULATING DEVICE:

Date of Service: _____

Diagnosis and Code: _____

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

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

Equipment:

☐ Cough Stimulating Device (E0482)

Mode:

☐ Manual
☐ Auto
☐ Patient Preference

Cough-Trak:

☐ On
☐ Off
☐ Patient Preference

Setting:

Inspiratory Pressure:_____ cm H2O

Inspiratory Time:_____ secs.

Expiratory Pressure:_____ cm H2O

Expiratory Time:_____ secs.

☐ Titrate inspiratory and expiratory pressures to achieve an effective cough.

Frequency:

☐ Two (2) times daily and as needed
☐ Other_____

Interface Method:

☐ Mask (A7020)
☐ Mouthpiece (A7020)
☐ Trach Adaptor (A7020)
☐ Filters 4/Month
☐ Corrugated Tubing (A7010) 4 /Month
☐ Battery
☐ Other_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient have a neuromuscular disease?

   ☐ Y ☐ N

2. Does the condition cause a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.

   ☐ 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: _____