


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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	Patient Name, Address, Telephone & HIC#: () - HIC#: . Patient DOB: / / Sex: (M/F)
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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 (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?

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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: _____