


**CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION  
COUGH STIMULATING DEVICE**

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

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>   <b>4215 Credit Union Dr.</b> <b>Anchorage, AK 99503</b> <b>Phone: (907) 274-0770      Fax: (907) 274-0773</b> <b>NSC#: 1267160001</b>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  (      )      -      HIC#:      .  <b>Patient DOB:      /      /      Sex:      (M/F)</b>
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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.

**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: \_\_\_\_\_