℞ 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 **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:_____

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)
☐ 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: _____