



Certificate of Medical Necessity –Invasive Ventilator Prescription

901 N Leatherleaf Loop
Wasilla, AK 99654
NSC# 1267160003
Phone:907-357-7882
Fax: 907-357-7883

Provider Name: _____

Phone/Fax: _____

Patient Name _____ DOB: _____

Address: _____

Home Phone: _____ Mobile Phone _____

Patient Height: _____ Weight: _____

Scheduled Date of Discharge from the hospital: _____

Duration of Equipment: [] Lifetime (99 months) [] Other:

ICD-10 Diagnosis and Code: _____

Settings:

AVAPS (Trilogy Modes only): Select a mode: PC, S/T, S, T

VT _____ ml (6-8mg/kg of IBW, NOT actual weight. IBW based on Ht) AVAPS Rate: _____ 5 (5 is

standard) Respiratory Rate (10 or 2 below resting resp. rate): _____ IPAP max (4-44, standard around 25): _____

IPAP min (standard between 5 and 10, +4 of EPAP): _____ EPAP (4-10, at least 4 below IPAP min)

SIMV: VT: _____ Rate: _____ PS: _____ PEEP: _____ I time: _____

AC: VT: _____ Rate: _____ PEEP: _____ I time: _____

PC-SIMV: _____ PEEP: _____ PS (above PEEP): _____ Rate: _____ I Time: _____

PC (Trilogy): IPAP: _____ EPAP: _____ Rate: _____ I Time: _____

PC (LTV): Pressure: _____ PEEP: _____

S/T or T: IPAP: _____ EPAP: _____ Rate: _____ I Time: _____ Rise Time (1-6): _____ Ramp (5-45 min): _____

S: IPAP: _____ EPAP (at least 4): _____ Rise Time: _____ Ramp: _____

CPAP: _____ Ramp: _____

Supplemental Oxygen (if applicable): FIO2 or LPM _____ Titrate O2 to maintain SaO2 > _____

Humidification (Circle One): Heated Humidifier or HME

TRACH TYPE and SIZE: _____

Hours of Use (Circle One): Continuous Other: _____

Supplies:

- [] Circuit, Disposable, Ventilator (A9900) – 5 per month
[] Bacteria Filter (A9999) – 5 per month
[] Temperature Probe (A9900) – 2 PRN
[] Adapter, Heated Wire (A9999) – 2 PRN
[] Water Chamber (A9900) – 1 per month
[] Sterile Water (A4217) – 31,000mL max/mo
[] Ventilator Check - 1 per month
[] Filter, Inlet (A9900) – 1 per month
[] IV Pole and bracket (E0776) – 1 PRN
[] Heated Inspiratory Line (A4618) – 5 per month
[] Exhalation Port (A9900) – 5 per month
[] Flex Adapter (A4649) – 5 per month
[] Ambu Bag (S8999)– 1 PRN _____ Pediatric _____ Adult
[] Inline Suction Catheter (A4605) Size _____ Qty _____
[] HME (A4483) 31 per month

Printed Physician Name: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____