


**RE CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION  
TRACHEOSTOMY CARE & AEROSOL COMPRESSOR HIGH VOLUME**

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; Insurance ID #:</b>  (      )      -      Ins ID#: _____  <b>Patient DOB:      /      /      Sex:      (M/F)</b>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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: \_\_\_\_\_

**TRACHEOSTOMY CARE SUPPLIES:**

Diagnosis and Code: \_\_\_\_\_  
 Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)  
 Patient Height: \_\_\_\_\_ ft. in.    Weight: \_\_\_\_\_ lbs.  
 Date of Tracheotomy: \_\_\_\_\_

- Supplies:
- Trach: Size \_\_\_\_\_ - 1 per 3 months
    - Cuffed
    - UnCuffed
  - Inner Cannula, Trach: Size \_\_\_\_\_ - 31 per month
  - Trach Mask (A7525) – 2 per month
  - Trach Ties/Collar (A7526) – 31 per month
  - Trach Care Kit (A4629) – 31 per month
  - Passy Muir Valve (L8501) - 1 per month
  - Thermovent T (A7507) - 62 per month
  - Saline, 5ML (A4216) - 1 box of 100 per quarter
  - Non-sterile Gauze, (A6216) - 1 pk per month
  - Gauze, Split, 4x4 (A6402) – 2 per day/60 month
  - Cotton Tip Applicators, Sterile (A9999) - 1 bx per month
  - Hydrogen Peroxide (A4244) - 1 per month
  - Other \_\_\_\_\_

**Aerosol Compressor:**

Date of Service: \_\_\_\_\_  
 Diagnosis and Code: \_\_\_\_\_  
 Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)  
 Patient Height: \_\_\_\_\_ ft. in.    Weight: \_\_\_\_\_ lbs.

- Equipment:
- Aerosol Compressor (E0565)
  - Heater (A9900/A9999)
- Supplies:
- Water Trap, Lg Volume (A7012) – 2 per month
  - Tubing, Corrugated (A7010) – 1 per 2 months
  - Nebulizer Cap, Large Volume (A7007) – 2 per month
  - Sterile Water for Inhalation (A4217) – 31,000mL/max
  - Heater Barrels (A9270) – 4 per month
  - Other \_\_\_\_\_

**MEDICAL NECESSITY INFORMATION:**

- REQUIRED CRITERIA
- Does the patient require replacement of the tracheostomy tube on a routine basis?  
 Y  N  
 Specific Frequency: \_\_\_\_\_
  - Does patient require routine trache cleaning more than one (1) time per day?  
 Y  N  
 Specific Frequency: \_\_\_\_\_

**MEDICAL NECESSITY INFORMATION:**

- REQUIRED CRITERIA
- Does the patient require humidity due to thick, tenacious secretions?  
 Y  N
  - Does the patient have cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent?  
 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: \_\_\_\_\_