



Certificate of Medical Necessity –Invasive Ventilator Prescription

901 N Leatherleaf Lp # 104
Wasilla, AK 99654
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Phone:907-357-7882
Fax: 907-357-7883

Provider Name:
Order Date:
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 only): Mode (circle one): 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): FI02 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) - 5 per month
Sterile Water Bags (A4217) - 30 per month
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) per month

Printed Physician Name:
NPI:
Address:
Phone:
Fax:

Physician Signature:
Date: