℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION

High Frequency Chest Wall Oscillation Device

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** **Fairbanks, AK 99701 Phone:** **(907) 458-8912 NSC#: Fax: (907) 458-8914** **1267160002**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

High Frequency Chest Wall Oscillation:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months): _____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Equipment:

☐ High Frequency Chest Wall Oscillation (E0483)

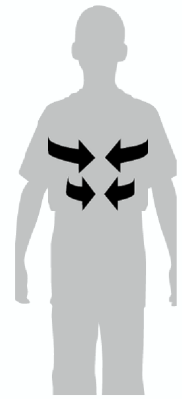
Frequency:

☐ Standard* 5Hz-20Hz for 30 min twice daily

☐ Custom* Use at ____Hz For____Min____Per Day

Device Measurement & Sizing:

Instructions: Have the patient remove outerwear and have them stand straight with arms at their side. Take chest measurement under the arms and across the largest part of chest and the same for the abdomen. Use the larger of the two.



☐ XXS 18"-23" (46-58cm)

☐ XS 23"-29" (58-74cm)

☐ S 29"-35" (74-89cm)

☐ M 35"-41" (104-122cm)

☐ L 41"-48" (104-122cm)

☐ XL 48"-55" (122-140cm)

☐ XXL 55"-65" (140-165+cm)

☐ ProCare to Size

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Airway Clearance Therapy has been Tried and Failed

☐ Y ☐ N

2. Which of the following treatment methods have been tried and failed?

☐ CPT (Manual or Percussor)

☐ PEP (Flutter/Acapella/Aerobika)

☐ Breathing Drainage Techniques

☐ Other_____

***Method must be documented in chart notes with F2F**

3. Has the patient had a Daily productive (mucus) cough for at least 6 continuous months?

☐ Y ☐ N

4. Has the patient had frequent (more than 2 year) exacerbations / chest infections requiring antibiotic therapy?

☐ 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: _____