℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
SUCTION MACHINE

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **3519 Industrial Avenue** **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. 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.

SUCTION MACHINE AND SUPPLIES:

Date of Service: _____

Diagnosis and Code: _____

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

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

Equipment:

- ☐ Suction Machine, Portable (E0600)
- ☐ Supply Kit (Includes: Canister (A7000), Conductive Tubing (A7002), Inlet Tube (A7002), Inline Filter (A9900), and Connector/Elbow (A9900)) - 2 per month

Type of Suction:

- ☐ Oral (Yankauer Tip) - 2 per month
- ☐ Tracheal (Suction Catheter) Size_____ - 90 per month
- ☐ Other_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient have difficulty raising and clearing secretions secondary to: Tracheostomy, Cancer, Surgery of the Throat, Dysfuction of the Swallowing Muscle and/or Unconsciousness of Obtund State?
   ☐ 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: _____