℞ 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 **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

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:_____

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 (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: _____