


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
SUCTION MACHINE**

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>  915 30th Avenue Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1267160002	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  ( ) - HIC#: . Patient DOB: / / Sex: (M/F)
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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 (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, Dysfunction 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: \_\_\_\_\_