


**& CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
TRACHEOSTOMY CARE & AEROSOL COMPRESSOR HIGH VOLUME**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	Patient Name, Address, Telephone & HIC#: () - HIC#: . Patient DOB: / / Sex: (M/F)
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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: _____

TRACHEOSTOMY CARE SUPPLIES:

Diagnosis and Code: _____
 Length of Need (# of months) _____ 1-99 (99=life)
 Patient Height: _____ ft. in. Weight: _____ lbs.
 Date of Tracheotomy: _____

- Supplies:
- Trach: Size _____ - 1 per 3 months
 - Cuffed
 - UnCuffed
 - Inner Cannula, Trach: Size _____ - 31 per month
 - Trach Mask (A7525) – 2 per month
 - Trach Ties/Collar (A7526) – 31 per month
 - TrachCare Kit (A4629) – 31 per month
 - Passy Muir Valve (L8501) - 1 per month
 - Thermovent T (A4483) - 62 per month
 - Saline, 5 ML (A4216) - 1 bx per month
 - Non-sterile Gauze, (A6216) - 1 pk per month
 - Gauze, Split, 4x4 (A6402) – 2 per day/60 month
 - Cotton Tip Applicators, Sterile (A9999) - 1 bx per month
 - Hydrogen Peroxide (A4244) - 3 per month
 - Other _____

Aerosol Compressor:

Date of Service: _____
 Diagnosis and Code: _____
 Length of Need (# of months) _____ 1-99 (99=life)
 Patient Height: _____ ft. in. Weight: _____ lbs.

- Equipment:
- Aerosol Compressor (E0565)
 - Heater (A9900/A9999)
- Supplies:
- Water Trap, Lg Volume (A7012) – 2 per month
 - Tubing, Corrugated (A7010) – 1 per month
 - Nebulizer Cap, Large Volume (A7007) – 2 per month
 - Sterile Water for Inhalation (A4217) – 31,000mL/max
 - Heater Barrels (A9270) – 4 per month
 - Other _____

MEDICAL NECESSITY INFORMATION:

- REQUIRED CRITERIA
1. Does the patient require replacement of the tracheostomy tube on a routine basis?
 Y N
 Specific Frequency: _____
 2. Does patient require routine trache cleaning more than one (1) time per day?
 Y N
 Specific Frequency: _____

MEDICAL NECESSITY INFORMATION:

- REQUIRED CRITERIA
1. Does the patient require humidity due to thick, tenacious secretions?
 Y N
 2. Does the patient have cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent?
 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: _____