Certificate of Medical Necessity –Invasive Ventilator Prescription

915 30th Avenue Suite 106
Fairbanks, AK 99701
NSC# 1267160002
Phone:907-458-8912
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Provider Name: ________________________

Phone/Fax: ___________________________

Patient Name______________________________DOB: ________________
Address:____
Home Phone:____________________________Mobile Phone ________________________________
Patient Height:_____Weight: __________
Scheduled Date of Discharge from the hospital: ________________________

Duration of Equipment: ☐ Lifetime (99 months) ☐ Other:

ICD-10 Diagnosis and Code: ____

Settings:
AVAPS (Trilogy Modes only): Select a mode: PC, S/T, S, T
VT____________ml (6-8mg/kg of IBW, NOT actual weight. IBW based on Ht) AVAPS Rate:____5 (5 is standard) Respiratory Rate (10 or 2 below resting resp. rate):______IPAP max (4-44, standard around 25): _____
IPAP min (standard between 5 and 10, +4 of EPAP):________EPAP (4-10, at least 4 below IPAP min)
SIMV: VT:_______Rate:________PS:_______PEEP:______I time: ______
AC: VT:_______Rate:_______PEEP:______I time: _______
PC-SIMV:______PEEP:______PS (above PEEP):_______Rate:_____I Time: ______
PC (Trilogy): IPAP:______EPAP:_____Rate:_____I Time: ______
PC (LTV): Pressure:________PEEP: __________
S/T or T: IPAP:_______EPAP:______Rate:______I Time:______Rise Time (1-6):______Ramp (5-45 min): ______
S: IPAP:_____EPAP (at least 4):______Rise Time:_____Ramp: _____
CPAP:_______Ramp: ______

Supplemental Oxygen (if applicable): FI02 or LPM______Titrate 02 to maintain Sa02 > ___________
Humidification (Circle One): Heated Humidifier or HME
TRACH TYPE and SIZE: _________________
Hours of Use (Circle One): Continuous Other: __________

Supplies:

- ❑ Circuit, Disposable, Ventilator (A9900) – 5 per month
- ❑ Bacteria Filter (A9999) – 5 per month
- ❑ Temperature Probe (A9900) – 2 PRN
- ❑ Adapter, Heated Wire (A9999) – 2 PRN
- ❑ Water Chamber (A9900) – 1 per month
- ❑ Sterile Water (A4217) – 31,000mL max/mo
- ❑ Ventilator Check - 1 per month
- ❑ Filter, Inlet (A9900) – 1 per month
- ❑ IV Pole and bracket (E0776) – 1 PRN
- ❑ Heated Inspiratory Line (A4618) – 5 per month
- ❑ Exhalation Port (A9900) – 5 per month
- ❑ Flex Adapter (A4649) – 5 per month
- ❑ Ambu Bag (S8999)– 1 PRN ____ Pediatric ____ Adult
- ❑ Inline Suction Catheter (A4605) Size ____ Qty_____
- ❑ HME (A4483) 31 per month

Printed Physician Name: ___________________________________ **NPI:** ________________
Address: ____

Phone:______________________________**Fax:** ____

Physician Signature:____**Date:**_________________