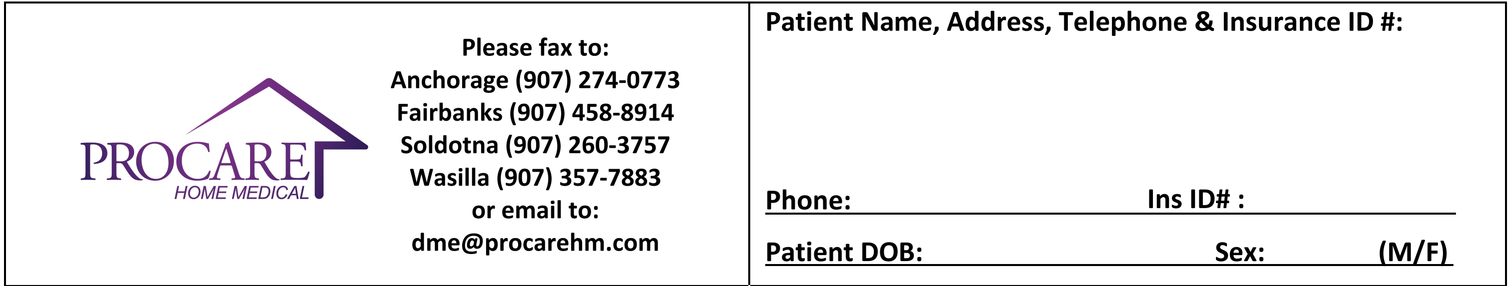
SUCTION MACHINE & SUPPLIES STANDARD WRITTEN ORDER



PROCARE HOME MEDICAL **Please fax to:** **Anchorage (907) 274-0773** **Fairbanks (907) 458-8914** **Soldotna (907) 260-3757** **Wasilla (907) 357-7883** **or email to:** **dme@procarehm.com**	**Patient Name, Address, Telephone & Insurance ID #:** **Phone:** ______________________ **Ins ID# :** ____________ **Patient DOB:** ______________________ **Sex:** ______ **(M/F)**

Refer to the suction machine coverage criteria sheet for all required documentation.

SUCTION MACHINE AND SUPPLIES:

Date of Last Visit: ________________________

Diagnosis and Code: ____

Length of Need (# of months)______________1-99 (99=life)   Patient Height: ________ in.   Weight: _______ lbs.

Equipment:

Suction Machine (E0600) with canister (2/month) and suction tubing (2/month)

Type of Suction:

Oral (Yankauer Tip) 12/mo   Tracheal (Suction Catheter) 90/mo Size: ___________

Other:______________________ Qty: __________

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: ________________ NPI: ________________

Provider's Name: ____ Telephone: ________________________________

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