HIGH FREQUENCY CHEST WALL OSCILLATION DEVICE 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#:

( ) - Ins ID#:

Patient DOB: / / Sex: (M/F)

Please fax order along with required documentation to (907) 274-0773 or email to dme@procarehm.com
Refer to the high frequency chest wall oscillation criteria sheet for all required documentation.

High Frequency Chest Wall Oscillation:

Diagnosis and Code: _____ Patient Height: _____ in. Weight: _____ lbs.

Length of Need (# of months): _____1-99 (99=life) Order Date: _____

Equipment:

☐ High Frequency Chest Wall Oscillation (E0483)

Frequncy::

☐ Standard* 5Hz-20Hz for 30 min twice daily

☐ Custom* Use at ____Hz For____Min____Per Day

Device Measurement & Sizing:

Have the patient remove outerwear and have them stand straight with arms at their side. Take chest measurement under the arms and across the largest part of chest and the same for the abdomen. Use the larger of the two.

☐ XXS 18"-23" (46-58 cm) ☐ XS 23-29" (58-74 cm) ☐ S 29"-35" (74-89 cm)
☐ M 35"-41" (89-104 cm) ☐ L 41"-48" (104-122 cm) ☐ XL 48"-55" (122-140 cm)
☐ XXL 55"-65" (140-165+ cm) ☐ Procare to size

MEDICAL NECESSITY INFORMATION:

Airway Clearance Therapy has been Tried and Failed ☐ Y ☐ N

Which of the following treatment methods have been tried and failed? *Method must be documented in chart notes with F2F

☐ CPT (Manual or Percussor) ☐ PEP (Flutter/Acapella/Aerobika) ☐ Breathing Drainage Techniques

☐ Other: _____

Has the patient had a daily productive (mucus) cough for at least 6 continuous months? ☐ Y ☐ N

OR

Has the patient had frequent (more than 2 year) exacerbations/chest infections requiring antibiotic therapy? ☐ 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 andcare provided.

Provider's Signature: _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____