COUGH STIMULATING 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 #:

Phone: _____ **Ins ID#:** _____

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

Please fax orders along with required documentation to **(907) 274-077**3 or email to dme@procarehm.com
Refer to the cough stimulating cover criteria sheet for all required documentation.

COUGH STIMULATING DEVICE:

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

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

Equipment:

Cough Stimulating Device (E0482)

Mode: ☐ Manual ☐ Auto ☐ Patient Preference Cough-Trek: ☐ On ☐ Off ☐ Patient Preference

Setting: Inspiratory Pressure: _____ cm H2O Inspiratory Time: _____ secs.

Expiratory Pressure: _____ cm H2O Expiratory Time: _____ secs.

☐ Titrate inspiratory and expiratory pressures to achieve an effective cough

Frequency:

☐ Two (2) times daily and as needed ☐ Other _____

Interface Method: ☐ Mask (A7020) ☐ Mouthpiece (A7020) ☐ Trach Adapter (A7020) *Medicare: 1/mo Medicaid: 1/yr Private: 2/month*

Supplies: ☐ Filters (A9900) 4/Month ☐ Other _____
☐ Battery

MEDICAL NECESSITY INFORMATION: *Must also be supported in medical records, if applicable*

1. Does the patient have a neuromuscular disease? ☐ Y ☐ N
2. Does the condition cause a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions? ☐ 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: _____ NPI: _____

Provider's Name: _____ Telephone: _____

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