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

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
PROCARE HOME MEDICAL **915 30th Avenue Suite 106** **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907)** 458-8914 **NSC#: 1267160002**	**( ) - Ins ID#:** . **Patient DOB: / / Sex: (M/F)**

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
- ☐ Trach Care Kit (A4629) – 31 per month
- ☐ Passy Muir Valve (L8501) - 1 per month
- ☐ Thermovent T (A7507) - 62 per month
- ☐ Saline, 5ML (A4216) - 1 box of 100 per quarter
- ☐ 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) - 1 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:_____

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 2 months
- ☐ 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 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: _____

Updated 01-07-21