TRACHEOSTOMY CARE & AEROSOL COMPRESSOR HIGH VOLUME
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)**

Refer to the aerosol compressor and tracheostomy supply coverage criteria sheet for all required documentation.

Date of last visit: _____

Diagnosis and Code: _____

Length of Need: _____ 1-99 (99=life) Date of Trachotomy: _____

AEROSOL COMPRESSOR:

Equipment:

☐ Aerosol Compressor (E0565) ☐ Heater (A9900/A9999)

Supplies:

☐ Trach Mask (A7525) - 2 per month
☐ Tubing, Corrugated (A7010) – 1 per 2 months
☐ Sterile water for Inhalation (A4217) – 31,000mL/max
☐ Water Trap, Lg Volume (A7012) – 2 per month
☐ Nebulizer Cap, Large Volume (A7007) – 2 per month
☐ Other: _____

TRACHEOSTOMY CARE SUPPLIES:

☐ Trach: Size _____ 1 per 3 months
☐ Inner Cannula - 31 per month
☐ TrachTies/Collar (A7526) – 31 per month
☐ Passy Muir Valve (L8501) - 1/quarter
☐ Saline, 5ML (A4216) - 1 box of 100 per quarter
☐ Gauze – 60/mo
☐ Cuffed ☐ UnCuffed Part #: _____
☐ Trach Mask (A7525) – 2 per month
☐ Trach Care Kit (A4629) – 31 per month
☐ Thermovent T (A7507) - 62 per month
☐ Cotton Tip Applicators, Sterile (A9999) - 1 box/mo Other:
☐ _____

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: _____