

**TRACHEOSTOMY CARE & AEROSOL COMPRESSOR HIGH VOLUME
STANDARD WRITTEN ORDER**

 <p style="text-align: center;">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</p>	<p>Patient Name, Address, Telephone & Insurance ID #:</p> <p>() - Ins ID#: .</p> <p>Patient DOB: / / Sex: (M/F)</p>
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Refer to the aerosol compressor and tracheostomy supply coverage criteria sheet for all required documentation.

Date of last visit: _____ Order Date: _____

Diagnosis and Code: _____

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

AEROSOL COMPRESSOR:

Equipment:

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

Supplies:

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

TRACHEOSTOMY CARE SUPPLIES:

- | | |
|---|--|
| Trach: Size _____ 1 per 3 months | <input type="checkbox"/> Cuffed <input type="checkbox"/> UnCuffed Part #: _____ |
| <input type="checkbox"/> Inner Cannula - 31 per month | <input type="checkbox"/> Trach Mask (A7525) – 2 per month |
| <input type="checkbox"/> TrachTies/Collar (A7526) – 31 per month | <input type="checkbox"/> Trach Care Kit (A4629) – 31 per month |
| <input type="checkbox"/> Passy Muir Valve (L851) - 1/quarter | <input type="checkbox"/> Thermovent T (A7507) - 62 per month |
| <input type="checkbox"/> Saline, 5ML (A4216) - 1 box of 100 per quarter | <input type="checkbox"/> Non-sterile Gauze <=16 sq in, (A6216) - 500/mo |
| <input type="checkbox"/> Sterile Gauze <=16 sq in, (A6402) – 60/month | <input type="checkbox"/> Cotton Tip Applicators, Sterile (A9999) - 1 box/mo Other: |
| <input type="checkbox"/> Hydrogen Peroxide (A4244) - 1 per month | <input type="checkbox"/> _____ |

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: _____