Non-Invasive Ventilator 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)

According to the CMS National Coverage Determination for DME (section 280.1), Non-Invasive Ventilators are: "Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease."

Order Date: _____ Date of Last Provider Visit: _____

Length of Need: _____

Diagnosis:

- ☐ Chronic Respiratory Failure (J96.10)
- ☐ Chronic Respiratory Failure w/ Hypoxia (J96.11)
- ☐ Chronic Respiratory Failure w/ Hypercapnia (J96.12)
- ☐ Acute/Chronic Resp. Failure (J96.20)
- ☐ Acute/Chronic Resp. Failure w/ Hypoxia (J96.21)
- ☐ Acute/Chronic Resp. Failure w/ Hypercapnia (J96.22)
  Consequent to: ☐ COPD (J44.9)

- ☐ ALS (G12.21)
- ☐ Multiple Sclerosis (G35)
- ☐ Myasthenia Gravis (G70.00)
- ☐ Muscular Dystrophy (G71.00)
- ☐ Paraplegia (G82.20)
- ☐ Quadraplegia (G82.50)
- ☐ Other: _____

- ☐ Sarcoidosis (D86.9)
- ☐ Obesity Hypoventilation Syndrome (E66.2)
- ☐ Pulmonary Fibrosis (J84.10)
- ☐ Interstitial Lung Disease (J84.9)

- ☐ Unspecified kyphosis, thoracic region (M40.204)
- ☐ Musculoskeletal Deformities (M95.9)
- ☐ Other: _____

NIV Settings & Supplies

☐ Non-Invasive Ventilator (HCPCS E0466)

Primary Settings:

☐ Volume Assured Pressure Support
Max Pressure_____ PS Min_____ PS Max_____
EPAP Min_____ EPAP Max_____ Vt_____

Additional Info:

☐ Respiratory Therapist to titrate pressures and/or adjust Vt for optimal therapy and patient comfort.

Supplies:

- ☐ Heated Humidifier - (A9999)
- ☐ Disposable H2o Chamber - 4/month (A9999)
- ☐ Reusable Ventilator Circuit - 1 every 3 months (A9900/A9999)
- ☐ Bacteria Filters - 4/month (A9999)
- ☐ PRN Filters: Air/Intake Filter 1/6 months Particulate Filter 1/month
  White Pollen Filter 2/month Fan Filter 1/6 months

Secondary Settings:

☐ Assist Control via Mouthpiece Ventilation Vt_____

☐ Pressure Control via Mouthpiece Ventilation
IPAP_____ EPAP _____

Frequency & Usage

☐ Continuous ☐ Nocturnal ☐ PRN

☐ Supplemental Oxygen Bleed In

- ☐ Sterile H2o - 31,000mL max/mo (A4217)
- ☐ Non-Invasive Interface (Patient Preference)
  Full Face Mask (A7030) – 1 every 3 months
  Full Face Cushion (A7031) – 1/month
  Nasal Mask (A7034) – 1 every 3 months
  Nasal Pillows/Cushions (A7032/A7033) – 2/month
- ☐ MPV Circuit-4/month(A4618)

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: _____