

Non-Invasive Ventilator Standard Written Order



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."

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 _____

Secondary Settings:

Assist Control via Mouthpiece Ventilation Vt _____
 Pressure Control via Mouthpiece Ventilation
 IPAP _____ EPAP _____

Additional Info:

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

Frequency & Usage

Continuous Nocturnal PRN
 Supplemental Oxygen Bleed In

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

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: _____