SUCTION MACHINE & SUPPLIES 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 #:** **Phone:** **Ins ID# :** **Patient DOB:** **Sex:** **(M/F)**

Refer to the suction machine coverage criteria sheet for all required documentation.

SUCTION MACHINE AND SUPPLIES:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life) Patient Height: _____ in. Weight: _____ lbs.

Equipment:

☐ Suction Machine (E0600)
☐ Supply Kit 2/month
(Includes: Canister (A7000), Conductive Tubing (A7002), Inlet Tube (A7002), Inline Filter (A9900), and Connector/Elbow (A9900))

Type of Suction:

☐ Oral (Yankauer Tip) 12/mo ☐ Tracheal (Suction Catheter) 90/mo Size: _____
☐ Other:_____ Qty: _____

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: _____