

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Estimated Length of Need (i.e. 99=lifetime)	ICD-10

HCPCS Code: E0465 – Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

**LTV 1150 Settings:**

SIMV       AC       CV       PC-SIMV       PC

Vt: _____	Breath Rate: _____	Inspiratory Time: _____	sigh <input type="checkbox"/> on <input type="checkbox"/> off	<input type="checkbox"/> Mouthpiece Ventilation (MPV)
Pressure: _____	PS: _____	PEEP: _____	Other: _____	

Supplemental Oxygen:	FiO2 / lpm: _____
Humidification:	<input type="checkbox"/> Heated Humidifier <input type="checkbox"/> Other _____

Hours of use       continuous       during sleep       other: \_\_\_\_\_

Second ventilator needed for portability (wheelchair mounted)?       Yes       No

Clinical assessment to be performed to determine device alarm settings

**Additional orders:**


**Please attach the following:**

- Progress notes/face to face evaluation indicating patient need for prescribed equipment/supplies
- Test results
- Patient demographics sheet

*In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.*

Physician Name:	Physician NPI:
Physician Address:	Physician Phone:
Physician Signature:	Date:
No stamps please – not valid by law	