

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

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

Circuit Type: Passive Active

Trilogy Settings:

SIMV AC CV PC-SIMV PC AVAPS

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

<input type="checkbox"/> AVAPS	IPAP min: _____	IPAP max: _____	Vt target: _____
	AVAPS rate: _____	Max Pressure: _____	

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

Download ventilation reports with DirectView software? Yes, download frequency _____ No

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	