

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

RX: High Humidity Trach Collar (Supplemental oxygen requires desat results) - # hrs of use per day: \_\_\_\_\_

<input type="checkbox"/> room air	<input type="checkbox"/> 24% = 1 LPM	<input type="checkbox"/> 28% = 2 LPM
<input type="checkbox"/> 32% = 3 LPM	<input type="checkbox"/> 36% = 4 LPM	<input type="checkbox"/> 40% = 5 LPM

**ADULT AEROSOL EQUIPMENT & SUPPLIES**

QTY / MONTH	DESCRIPTION		HCPC	PART #
<input type="checkbox"/> 1 ea/month	Rental	50PSI Compressor	E0565	PM15
<input type="checkbox"/> 1 ea/month	Purchase	Corrugated tubing	A7010	1680
<input type="checkbox"/> 2 ea/month	Purchase	Large volume nebulizer bottle (change q2 weeks)	A7007	1770
<input type="checkbox"/> 2 ea/month	Purchase	Aerosol drainage bag (change q2 weeks)	A7012	001562
<input type="checkbox"/> 1 ea/month	Purchase	Trach mask (allowable dependent on insurance)	A7525	T237
<input type="checkbox"/> 1 ea/3 months	Purchase	Filter for Drive 50PSI	E1399	18450-filter

**SUCTION EQUIPMENT & SUPPLIES**

QTY / MONTH	DESCRIPTION		HCPC	PART #
<input type="checkbox"/> 1 ea/month	Rental	Portable suction machine	E0600	7305PD
<input type="checkbox"/> 90 ea/month	Purchase	Suction catheter size: <input type="checkbox"/> 8fr (T182), <input type="checkbox"/> 10fr (T183), <input type="checkbox"/> 12fr (T184), <input type="checkbox"/> 14fr (T185)	A4624	(check in description)
<input type="checkbox"/> 2 ea/month	Purchase	Suction connective tubing	A7002	SUCTUBE72
<input type="checkbox"/> 2 ea/month	Purchase	Suction canister & lid	A7000	IRC1140
<input type="checkbox"/> 1 ea/month	Purchase	Filter/tubing kit for portable suction	A7013	AG5604
<input type="checkbox"/> 1 ea/month	Purchase	Yankauer suction catheter (for oral cleansing)	A4628	T245

**TRACHEOSTOMY SUPPLIES (If Medicare Insurance: Home Health agency is responsible)**

QTY / MONTH	DESCRIPTION		HCPC	PART #
<input type="checkbox"/> 1 ea/3 months	Purchase	Tracheostomy tube Manufacturer part #: _____	A7520	(check in description)
<input type="checkbox"/> 30 ea/month	Purchase	Tracheostomy tube inner cannula Manufacturer part #: _____	A4623	(check in description)
<input type="checkbox"/> 30 ea/month	Purchase	Trach tube holder (1 ea/day) <input type="checkbox"/> Small: 597S <input type="checkbox"/> Medium: 597M <input type="checkbox"/> Large: 597L	A7526	(check in description)
<input type="checkbox"/> 30 ea/month	Purchase	Trach cleaning kits: includes 4x4, 4x4 split, glove (1 ea/day)	A4629	T180
<input type="checkbox"/> 30 ea/month	Purchase	HME Thermovents for ambulation (1 ea/day)	A7507	T134

**STEP DOWN TRACH TUBE AND RESUSCITATION BAG MUST BE SENT HOME WITH PATIENT**

**Please attach the following:**

- Progress notes/face to face evaluation indicating patient need for prescribed equipment/supplies
- Test results
- Patient demographics sheet
- If supplemental oxygen is prescribed, please include WOPD for oxygen

*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