Medical Service Company

Please fax completed form to 1-877-824-1411

AIRWAY CLEARANCE VEST THERAPY Fax Order Form

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____ ***Date Prescribed:*** _____ /_____ /_____

Address: _____ Insurance: _____

City/Zip: _____ Gender: _____ Length of need: 99

Home Phone/Cell#: _____ Primary Diagnosis: _____

Date of Birth: _____ ICD-10 Diagnosis Code: _____

Chest Circumference: _____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

Abdomen Measurement: _____

AIRWAY CLEARANCE THERAPY *Tried and Failed. This must be documented in the patient's progress notes.*

1. Have alternative airway clearance techniques been tried and failed? ☐ Yes ☐ No

   Please indicate methods of airway clearance patient has tried and failed (check all that apply):

   ☐ CPT (manual or percussor) ☐ Hypertonic Saline ☐ Suctioning ☐ Mucomyst* *(*Notes must document it prescribed for secretion mobilization)*

   ☐ Huff Coughing ☐ Breathing Techniques ☐ Oscillating PEP (Flutter, Acapella®, Aerobika®, Pep Valve, Pep Mask)

2. Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient:

   ☐ Cannot tolerate positioning/hand CPT ☐ Cognitive level ☐ Severe arthritis, osteoporosis ☐ Insufficient expiratory force

   ☐ Physical limitations of caregiver ☐ Too fragile for hand CPT ☐ Unable to form mouth seal ☐ Resistance to therapy

   ☐ Caregiver unable to perform adequate CPT ☐ Gastroesophageal reflux (GERD) ☐ Did not mobilize secretions ☐ Artificial airway

3. For Cystic Fibrosis or Neuromuscular patients, the following must be documented in the patient's progress notes. ***Please attach records with RX.***

   ☐ Documentation supporting diagnosis ☐ Tried and failed a lesser airway clearance technique indicated above

4. For Bronchiectasis patients, the CT scan and diagnosis of bronchiectasis must be recorded in the radiologist's report.

   Has there been a CT scan confirming Bronchiectasis diagnosis? ☐ Yes ☐ No ***If "Yes" please include copy of CT scan interpretation.***

   In addition, the following medical history in the past year must be documented in the patient's progress notes. ***Please attach records with RX.***

   ☐ 3 or more exacerbations (i.e lung infections) requiring antibiotics documented at least 3 separate times **OR**

   ☐ Daily productive cough for at least 6 continuous months

RX: HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO); HCPCS E0483

Start Date: _____ Check need of Length: ☐ Lifetime (99) ☐ Other: _____

☐ Standard Prescription: Use the HFWCO at 5Hz–20Hz for 30 minute treatments twice per day (minimum of 15 minutes per day)

☐ Custom Prescription: Use the HFWCO at _____ Hz for _____ minute treatments _____ per day

☐ Please check box if nebulizer therapy to be used in conjunction with HFCWO

I certify the accuracy of this Rx for the Airway Clearance Vest Therapy System and that I am the physician identified in this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge.

Physician's Signature: _____ ***Date:*** _____/_____/_____

Physician's Printed Name: _____ Ph: _____ Fax: _____

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

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