Medical Service Company

Cough Assist Order Form

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

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

Date of Birth: ____ / ____ / ____ **Length of Need: 99 months (lifetime) OR** ____ **# of months)**

Home Phone/Cell #: _____ **ICD-10 (Diagnosis):** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

COUGH ASSIST EQUIPMENT

☐ Cough Assist Therapy (Mechanical In-exsufflation) Device (E0482)

REPLACMENT SUPPLIES

☐ Interface for Cough Stimulating Device (A7020) includes mouthpiece, mask, tracheostomy

Size (check box):

☐ Small ☐ Medium ☐ Large

SETTINGS

The standard will be followed if any or all sections of the custom protocol are blank. Settings may be adjusted to patient comfort.

	Standard	Custom
Treatments/day	2	
Inhale/Exhale Pressure	(+/-) 5 - 70 cm h20	
Pause Pressure	1 - 15 cm h20	
Inhale/exhale/pause time	0 - 5 seconds	
Comfort settings (inspiratory trigger, advanced settings, flow)	Adjust to patient comfort	
Oscillation settings (frequency and amplitude)	Adjust to patient comfort	

INCLUDE THIS DOCUMENTATION TO DISPENSE AND BILL:

☐ **Documentation signed and dated by the physician to support the patient:**

- has a neuromuscular disease,

AND

- is **clinical impairment**, i.e., weakened chest wall or diaphragm causing ineffective clearance of secretions,

AND

- any **failed trials of standard airway clearance therapies** (e.g., chest physiotherapy, PEP devices) if combining therapies—especially relevant when also using other airway clearance devices

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

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____