Medical Service Company

Select Branch

AIRWAY CLEARANCE VEST THERAPY Fax Order Form

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

Patient Name: ______________________________

Address: ______________________________

City/Zip: ______________________________

Home Phone/Cell#: ______________________________

Date of Birth: ______________________________

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

Date Prescribed: ________ /________ /________

Insurance: ______________________________

Gender: ____________ Length of need: ____99____

Primary Diagnosis: ______________________________

ICD-10 Diagnosis Code: ______________________________

Chest Circumference: ______________________________

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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