smartvest
AIRWAY CLEARANCE SYSTEM

Prescription and Certificate of Medical Necessity

Please attach **Patient Demographic/Face Sheet**, **Copy of Insurance Card**, **signed Patient Agreement Form** and **Medical Records**. **FAX** all documents to **866-758-5077.** Questions? Please call **Electromed, Inc.** at 800-462-1045**.**

Name: (Last) ________________________ (First) ________________________ (Middle Initial) ________

Street________________________ City________________________ State________ Zip__________

Evening Phone: ________________ Daytime Phone: ________________ Cellular: ________________

Date of Birth: ________________ Primary Language: ________________ SS#:________________ M☐ F☐

Primary Diagnosis: ____ Code: ____________

Secondary Diagnosis: ____ Code: ____________

For Garment sizing: Height:________________ Weight: ____________ Chest Circumference: ____________

Airway Clearance Therapy Tried and Failed. This must be documented in the patient's progress notes.

☐ CPT (Manual or Percussor) ☐ Oscillating PEP ☐ Flutter/Acapella ☐ Suctioning
☐ Breathing Techniques ☐ Cough Assist ☐ Autogenic Drainage ☐ Cannot Use Other Forms

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

☐ Unable to tolerate positioning/percussion ☐ No caregiver available ☐ Physical limitations of caregiver
☐ Severe arthritis/osteoporosis ☐ Cognitive level ☐ Physical limitations of patient
☐ Gastroesophageal reflux (GERD) ☐ Aspiration risk ☐ Kyphosis/scoliosis
☐ Spasticity/contractures ☐ Resistance to therapy ☐ Too fragile for percussion
☐ Feeding tube ☐ Young age ☐ Unable to form mouth seal
☐ Did not mobilize secretions ☐ Artificial airway ☐ Insufficient expiratory force

Medical History in The Past Year. This must be documented in the patient's progress notes.

☐ Hospitalizations due to pulmonary exacerbation ☐ Mucus Plugs ☐ ER visits due to pulmonary exacerbation
☐ History of respiratory infections ☐ Atelectasis ☐ Sputum tested positive for resistant bacteria
☐ 3 exacerbations requiring antibiotics ☐ IV antibiotics ☐ Oral antibiotics
☐ Y ☐ N Daily productive cough for at least 6 months ☐ Decline in Pulmonary function/ PFTs - Current FEV1: ________________

If Bronchiectasis, is there a CT scan confirming diagnosis? ☐ Y **(attach report)** ☐ N **Date of last Face-to-Face Encounter:** ________

Physician Statement of Medical Necessity: ____

____

Rx: SmartVest® Airway Clearance System, HCPCS: E0483

Qty: 1/999 **Length of need:** 99 **Protocol:** Tx/Day – 2. **Frequencies** – 6 to 16 HZ. **Minutes per frequency** – 5 to 10.

Pressure to be set and adjusted per patient comfort and therapeutic benefit Minimum use per day – 15 minutes. Use settings best tolerated by patient.

I certify that this standard Rx is for the SmartVest® Airway Clearance System for Lifetime use. I certify that I am the physician identified in this form. I have reviewed all sections of the physician's written order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has or will complete training in utilizing the products prescribed in this Written Order. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and physician notes will be provided to Electromed and/or an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. By faxing this form I am acknowledging that the patient is aware that Electromed and/or an authorized distributor may be contacting them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

____ ____________
Physician Signature (stamped signature not accepted) Date

____ ____________
Physician Name (print) NPI

____________ ____________ ____________
Contact Phone Fax

____
Institution

____
Address

Individualized Protocol

(Takes Precedence if completed)

____
Tx/day

____
Frequencies

____
Minute/Frequency

____
Minimum use/Day