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: _____ Language: _____ Interpreter needed ☐ M ☐ F ☐

ICD-10 Dx Code: _____ Primary Diagnosis: _____

ICD-10 Dx Code: _____ Secondary Diagnosis: _____

For garment sizing: Height:_____ Weight: _____ Chest Circumference: _____

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

☐ Hypertonic Saline ☐ Mucomyst ☐ Incentive Spirometry ☐ Suctioning ☐ PEP / Flutter / Acapella

☐ Breathing techniques ☐ Cough Assist Device ☐ CPT (Manual or Percussor) ☐ Other: _____

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

☐ Artificial airway ☐ Gastroesophageal reflux ☐ Osteoporosis ☐ Too fragile for percussion

☐ Aspiration risk ☐ Insufficient expiratory force ☐ Resistance to therapy ☐ Unable to form mouth seal

☐ Cognitive level ☐ Kyphosis/scoliosis ☐ Severe arthritis ☐ Unable to tolerate positioning/percussion

☐ Did not mobilize secretions ☐ No caregiver available ☐ Spasticity/contractures ☐ Other: _____

Medical history in the past year. This must be documented in the patient's progress notes. Please attach records with Rx.

☐ CT scan ☐ Y **(attach report)** ☐ N

☐ 3 or more exacerbations requiring antibiotics, documented at least three separate times, OR

☐ Daily productive cough for at least 6 months

Date of last face-to-face encounter: _____

Rx: SmartVest® Airway Clearance System, HCPCS: E0483

Qty: 1/999 **Length of need:** 99 months=lifetime **Protocol:** Tx/Day – 2 **Frequencies** – 6 to 16 HZ **Minutes per treatment** – 15

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 Institution NPI

_____

Address

Individual Protocol

(Takes precedence if completed)

_____ Tx/day

_____ Frequencies

_____ Pressure

_____ Minute/Treatment

_____ Minimum use/Day