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 ☐ CPT (Manual or Percussor) ☐ Other: _____

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

☐ Artificial airway
☐ Aspiration risk
☐ Cognitive level
☐ Did not mobilize secretions
☐ Gastroesophageal reflux
☐ Insufficient expiratory force
☐ Kyphosis/scoliosis
☐ No caregiver available
☐ Osteoporosis
☐ Resistance to therapy
☐ Severe arthritis
☐ Spasticity/contractures
☐ Too fragile for percussion
☐ Unable to form mouth seal
☐ Unable to tolerate positioning/percussion
☐ 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 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 Institution NPI

_____
Address

Individual Protocol
(Takes precedence if completed)

_____
Tx/day

_____
Frequencies

_____
Pressure

_____
Minute/Frequency

_____
Minimum use/Day

smartvest®
AIRWAY CLEARANCE SYSTEM

PATIENT DEMOGRAPHICS FORM

INSTRUCTIONS
When complete please **fax** directly to Electromed, Inc. at **866-758-5077.** Please attach **signed Patient Agreement Form.** Questions? Please call **Electromed, Inc.** at 800-462-1045**.**

PATIENT INFORMATION

Name: (Last) _____ (First)_____ (Middle Initial)_____

Street Address:_____

City:_____ State:_____ Zip code:_____

Evening Phone:_____ Daytime Phone:_____ Cellular:_____

Date of Birth:_____ SS#:_____ M☐ F☐

Guardian/relationship:_____

Primary DX code:_____ Primary Diagnosis:_____

Secondary DX Code:_____ Secondary Diagnosis:_____

INSURANCE INFORMATION - Will accept printout of insurance information

Primary Insurer:_____ Telephone #:_____

ID #:_____ Group #:_____

Insured:_____ Insured's DOB:_____ Relationship to insured:_____

Secondary Insurer:_____ Telephone:_____

ID #:_____ Group #:_____

Insured:_____ Insured's DOB:_____ Relationship to insured:_____

HEALTHCARE TEAM (including **PRESCRIBING PHYSICIAN)**

Clinic Name:_____ Clinic Telephone #:_____

Clinic Address: _____

Clinic City:_____ State:_____ Zip code:_____

Clinic Contact Name:_____ Contact telephone #:_____

Clinic Contact E-mail:_____ Clinic Fax #:_____

Physician Name:_____ Physician NPI:_____

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New Prague, MN 56071
Phone: 952-758-9299
Fax: 866-758-5077
www.smartvest.com

Electromed, Inc.
500 Sixth Ave. N.W.
New Prague, MN 56071
Phone: 952-758-9299
Fax: 952-758-1941

PATIENT AGREEMENT AND CONSENT FORM

Patient Name: _____ **Date of Birth:** _____

Home Address: _____

Insurance Plan(s): _____

Other Entities (ex. Physicians, Clinics): _____

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I consent to the use and disclosure of my Protected Health Information (PHI) by Electromed, Inc. and its affiliates for treatment and payment purposes. I authorize Electromed to communicate with my insurer (s) and with any of my health care providers involved in my care as it relates to this medical treatment as necessary. The Notice of Privacy Practices, which outlines Electromed's privacy practices and my individual rights and responsibilities under HIPAA, is available for review on Electromed's website **www.electromed.com**, or a copy can be provided to you upon request. This authorization includes all PHI about me that has been created or received by Electromed. I can contact the Electromed Privacy Officer toll free at 1-800-462-1045 ext. 3384 if I have questions or concerns about Electromed's Notice of Privacy Practices or my individual HIPAA rights. This authorization will remain in effect for a period of one (1) year or until billing and/or appeals have been completed or until I revoke the authorization in writing, whichever is earlier.

Assignment of Benefits

I authorize Electromed to submit claims and other information necessary to bill my health insurance and/or benefit plan (Plan). I also authorize and request that any and all payments for the purchase and/or rental of equipment be made directly to Electromed or its assignments and/or an authorized distributor. I agree to endorse and forward any payments made to me by my Plan to Electromed for services billed under this Agreement.

Appeal Consent

If my Plan denies coverage for this equipment, I give permission for Electromed to initiate and act as my representative in the appeal process. I agree to fully cooperate with Electromed during the appeal process. I understand Electromed will not charge me to appeal with my Plan. I may revoke my permission to appeal at any time. I understand that Electromed makes no guarantee of a favorable appeal outcome.

Patient Compliance Responsibility

I understand that my Plan may require treatment compliance information from me. I agree to respond to Electromed's request and to provide this information promptly. If I am not responsive to these requests, reimbursement for this equipment may be adversely affected.

Patient Financial Responsibility

Electromed will make every effort possible to obtain complete payment from my insurance Plans. I will be responsible for payment of any amount not covered by my insurance Plan, including but not limited to copayments, coinsurance, deductibles, non-covered services. I understand that if my insurance plan does not cover the device or provide reimbursement for it, I have several options: 1) I can purchase the device directly. 2) I can choose to purchase the device through Electromed's flexible financing program. 3) I can contact Electromed at 1-888-966-2525 for return instructions within 30 days of receiving notice that my insurance will not cover the device and request to return the equipment at no additional cost to me. (Electromed will provide the shipping materials necessary and will cover shipping costs).

Additional Terms and Conditions

The person signing this authorization may receive a copy of this authorization upon request. NOTE: A duplicate copy of this document shall be considered the same as the original. By signing this, I agree to all the terms and conditions stated above.

Patient Signature: _____ **Date:** ___/____/____

Authorized Representative Signature (if applicable): _____ **Date:** ___/____/____

Authorized Representative Name and Phone No. (if applicable): _____

If signed by Authorized Representative, please confirm the nature of your relationship with Patient:

_____ **and check reason why Patient is unable to sign:**

☐ **Patient is a minor under the age of 18 years and parent or legal guardian signature is required.**

☐ **Patient is not competent to give consent due to a physical or mental condition.**

☐ **Other (please specify):** _____

Electromed, Inc.
500 Sixth Ave. N.W.
New Prague, MN 56071
Teléfono: +1 952-758-9299
Fax: +1 952-758-1941

Controlled Copy

FORMULARIO DE ACUERDO Y CONSENTIMIENTO DEL PACIENTE

Nombre del paciente: _____ **Fecha de nacimiento:** _____

Domicilio particular: _____

Plan(es) de seguro: _____

Otras entidades (por ej., médicos, clínicas): _____

Health Insurance Portability and Accountability Act (Ley de Transferibilidad y Responsabilidad de la Información de los seguros de salud de los Estados Unidos) promulgada en 1996 (HIPAA)

Autorizo el uso y la divulgación de mi información médica protegida por parte de Electromed, Inc. y sus afiliadas a los fines del tratamiento y el pago. Autorizo a Electromed a comunicarse con mi(s) aseguradora(s) y con cualquiera de mis proveedores de atención médica involucrados en mi atención respecto de mi tratamiento médico, según sea necesario. El Aviso de prácticas de privacidad, donde se reseñan las prácticas de privacidad de Electromed, así como mis derechos y responsabilidades individuales de conformidad con la ley HIPAA, está disponible para su consulta en el sitio web de Electromed www.electromed.com, o podemos brindarle una copia si la solicita. Esta autorización incluye toda la información médica protegida sobre mí que fue creada o recibida por Electromed. Puedo comunicarme con el Oficial de Privacidad de Electromed por teléfono, gratis, al 1-800-462-1045, interno 3384 si necesito información adicional o si tengo dudas sobre el Aviso de prácticas de privacidad de Electromed o mis derechos individuales según la ley HIPAA. Esta autorización tendrá vigencia durante un (1) año, hasta que finalice el proceso de facturación o de las apelaciones o bien, hasta que revoque la autorización por escrito, lo que ocurra primero.

Cesión de beneficios

Autorizo a Electromed a presentar pedidos de reembolso de gastos y toda la información necesaria para facturar a mi seguro médico o plan de beneficios (Plan). También autorizo y solicito que todos y cada uno de los pagos por la compra o el alquiler de equipos se efectúen directamente a Electromed o a sus cesionarios o distribuidor autorizado. Acepto endosar y enviar todos los pagos que me realice mi Plan a Electromed por los servicios facturados de conformidad con este Acuerdo.

Consentimiento para apelar

Si mi Plan rechaza la cobertura de este equipo, otorgo permiso a Electromed para iniciar y actuar como mi representante en el proceso de apelación. Acepto cooperar plenamente con Electromed durante el proceso de apelación. Entiendo que Electromed no me cobrará por apelar a mi Plan. Puedo revocar mi permiso para apelar en cualquier momento. Entiendo que Electromed no garantiza de ninguna manera que el resultado de la apelación será favorable.

Responsabilidad de cumplimiento del paciente

Entiendo que mi Plan puede exigirme información sobre el cumplimiento del tratamiento. Acepto responder a la solicitud de Electromed y suministrar esta información con prontitud. Si no respondo a estas solicitudes, el reembolso de este equipo podría resultar afectado de modo adverso.

Responsabilidad económica del paciente

Electromed hará todo lo que esté a su alcance para que mi Plan efectúe el pago completo de mis Planes de seguro. Deberé pagar toda suma que mi Plan no cubra incluidos, sin limitaciones, los copagos, el coseguro, los gastos deducibles y los servicios no cubiertos. Entiendo que si mi plan de seguro no cubre el dispositivo o si no reembolsa su costo, tengo varias opciones: 1) Puedo comprar el dispositivo directamente. 2) Puedo comprar el dispositivo a través del programa de financiamiento flexible de Electromed. 3) Puedo comunicarme con Electromed al 1-888-966-2525 para obtener instrucciones de devolución dentro de los 30 días de recibir el aviso de que mi aseguradora no cubre el dispositivo y solicitar la devolución del equipo, que no tendrá un costo adicional para mí. (Electromed proporcionará los materiales de envío necesarios y cubrirá los costos de envío).

Términos y condiciones adicionales

La persona que firma esta autorización puede recibir una copia de la misma si la solicita. NOTA: Los ejemplares duplicados de este documento serán considerados equivalentes al original. Al firmar este documento, acepto todos los términos y las condiciones indicados arriba.

Firma del paciente: _____ **Fecha:** ___/____/____

Firma del representante autorizado (si corresponde): _____ **Fecha:** ___/____/____

Nombre del representante autorizado y n.º de teléfono, (si corresponde): _____

Si la firma es del representante autorizado, confirme la naturaleza de su relación con el paciente:

_____ **y marque el motivo por el cual el paciente no puede firmar:**

_____ **El paciente tiene menos de 18 años de edad y se necesita la firma de uno de sus padres o el tutor legal.**

_____ **El paciente está incapacitado para prestar su consentimiento debido a una enfermedad física o mental.**

_____ **Otro (sírvase especificar):** _____