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) Smith (First) Joe (Middle Initial) M.
Street 1234 First Ave City Springfield State IN Zip 55554
Evening Phone: 123-555-4444 Daytime Phone: 123-544-4321 Cellular: 321-444-7546
Date of Birth: 1/1/2001 Primary Language: English SS#: 123-45-6789 M ☒ F ☐
Primary Diagnosis: Cystic Fibrosis Code: 277.00
Secondary Diagnosis: N/A Code: N/A
**For Garment sizing:** Height: 36" Weight: 40lbs Chest Circumference: 24"

**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: | |

**Date of last Face-to-Face Encounter:** 12/1/2014

**Complete for Bronchiectasis patient:** Is there a CT scan confirming Bronchiectasis diagnosis? ☐ Y ☐ N **If yes, attach required report.**

**Physician Statement of Medical Necessity:** Patient is not a good candidate for manual CPT, has difficulty clearing secretions.

## 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.

Robert Pepper MD — Physician Signature (stamped signature not accepted)
10/1/13 — Date
Dr. Robert Pepper — Physician Name (print)
123456789 — NPI
Mary Jo Fritz — Contact
456-223-4512 — Phone
456-223-4513 — Fax
South Metro Pulmonary Associates, 111 Lung Drive, South Bend, IN 55542 — Institution

**Individualized Protocol**
(Takes Precedence if completed)

Tx/day
Frequencies
Minute/Frequency
Minimum use/Day