smartvest
AIRWAY CLEARANCE SYSTEM

Prescription and Certificate of Medical Necessity

Attach **Patient Demographic/Face Sheet**, **Copy of Insurance Card**, **signed Patient Agreement Form** and **Medical Records**. **FAX** all documents to **866-758-5077** or **ePrescribe on Parachute**. 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: _____

Documentation Requirements	Included?
Face-to-Face Encounters *(one within last 6 months)*	☐
CT confirming Bronchiectasis *(required for Bronchiectasis)*	☐
Daily productive cough for more than 6 months, OR **3 or more exacerbations requiring antibiotics in the last 12 months**	☐
Tried and Failed Airway Clearance Therapy *(all diagnoses)* ☐ Hypertonic Saline ☐ Mucomyst ☐ Incentive Spirometry ☐ PEP / Flutter / Acapella ☐ Breathing techniques ☐ Cough Assist Device ☐ CPT (Manual or Percussor) ☐ Suctioning ☐ Other_____	☐

Physician Statement of Medical Necessity: _____

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 the medical necessity information is true, accurate, and complete to the best of my knowledge. 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. 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

_____ _____
Hospital Hospital NPI

_____
Address

Individual Protocol
(Takes precedence if completed)

_____ Tx/day

_____ Frequencies

_____ Pressure

_____ Minute/Treatment

_____ Minimum use/Day