Reset Form

ADVANCED MEDICAL SOLUTIONS

517-548-1443 OPTION 5 FAX: 517-548-1585

DETAILED WRITTEN ORDER FOR TRACHEOSTOMY SUCTION SUPPLIES, AND/OR TRACHEOSTOMY HUMIDITY

Patient Name: _____ Patient ID: _____

DOB: _____ Height: _____ Weight: _____ Length of Need: _____

Diagnosis: _____

ICD 10 Codes: _____ _____ _____ _____ _____

Prescription Date: _____ Discharge Date: _____

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:
*****Reason for Medical Necessity (other than diagnosis): _____**

	HCPCS CODE	DESCRIPTION	SIZES	QUANTITY PER MONTH
☐	E0600	Suction Machine	N/A	1 Unit
☐	A7000/02	Suction Canister w/ Tubing	N/A	4 Units
☐	E0565	Compressor	N/A	1 Unit
☐	A7010	Tubing	100 Fr	1 Unit
☐	A7525	Trach Masks	☐ Ped ☐ Adult	1 Unit
☐	A7012	Drain Bag	N/A	1 Unit
☐	A7007	Nebulizer Jar	N/A	4 Units
☐	A4624	Suction Catheter Kits	_____ Fr.	90 Units
☐	A4628	Yankauer Catheters	N/A	2 Units
☐	A7520	Tracheostomy Tube ☐ Cuffed ☐ Cuffless ☐ Fenestrated ☐ non-Fenestrated	Item #_____	1 Unit
☐	A4623	Disposable Inner Cannulas	Item #_____	30 Units
☐	A4629	Trach Care Kits	N/A	30 Units
☐	A7526	Trach Collar/Ties	N/A	30 Units
☐	A4216	Saline 3cc	N/A	100 Units
☐	A6402	Gauze	N/A	100/50 each

Notes	

Ordering Physician	
	Name: _____ NPI Number: _____
	Signature: _____ Signature Date: _____