High Frequency Chest Wall Oscillation Device Standard Written Order

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Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

HIGH FREQUENCY CHEST WALL OSCILLATION:

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Equipment:

☐ High Frequency Chest Wall Oscillation (E0483)

Frequency:

☐ Standard * 5Hz-20Hz for 30 min twice daily

☐ Custom* Use at _____ Hz For ____ Min ____ Per Day

Device Measurement & Sizing

Have the patient remove outerwear and have them stand straight with arms at their side. Take chest measurement under the arms and across the largest part of the chest, and the same for the abdomen. Use the larger of the two.

☐ XXS 18”-23” (46-58 cm) ☐ XS 23”-29” (58-74 cm) ☐ S 29”-35” (74-89 cm)
☐ M 35”-41” (89-104 cm) ☐ L 41”-48” (104-122 cm) ☐ XL 48”-55” (122-140 cm)
☐ XXL 55”-65” (140-165+ cm) ☐ Triton to Size

Provider Certification:

I, the patient’s treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider’s Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____