Non-Invasive Ventilator 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.

Length of Need (# of months) _____ 1-99 (99=lifetime) Date of Last Visit: _____

Diagnosis:

- ☐ Chronic Respiratory Failure (J96.10)
- ☐ Chronic Respiratory Failure w/ Hypoxia (J96.11)
- ☐ Chronic Respiratory Failure w/ Hypercapnia (J96.12)
- ☐ Acute/Chronic Resp. Failure (J96.20)
- ☐ Acute/Chronic Resp. Failure w/ Hypoxia (J96.21)
- ☐ Acute/Chronic Resp. Failure w/Hypercapnia (J96.22)
  - Consequent to: ☐ COPD (J44.9)
- ☐ Sarcoidosis (D86.9)
- ☐ Obesity Hypoventilation Syndrome (E66.2)
- ☐ Pulmonary Fibrosis (J84.10)
- ☐ Interstitial Lung Disease (J84.9)
- ☐ ALS (G12.21)
- ☐ Multiple Sclerosis (G35)
- ☐ Myasthenia Gravis (G70.00)
- ☐ Muscular Dystrophy (G71.00)
- ☐ Paraplegia (82.20)
- ☐ Quadriplegia (G82.50)
- ☐ Other: _____

- ☐ Unspecified kyphosis, thoracic region (M40.204)
- ☐ Musculoskeletal Deformities (M95.9)
- ☐ Other: _____

HIV SETTINGS & SUPPLIES:

☐ Non-Invasive Ventilator (HCPCS E0466)

Primary Settings:

☐ Volume Assured Pressure Support

Max Pressure _____ PS Min _____ PS Max _____

EPAP Min _____ EPAP Max _____ Vt _____

Additional Info:

☐ Respiratory Therapist to titrate pressures and/or adjust Vt for optimal therapy and patient comfort.

Supplies:

- ☐ Heated Humidifier (A9999)
- ☐ Disposable H2O Chamber – 4/month (A9999)
- ☐ Reusable Ventilator Circuit – 1 every 3 months (A9900/A9999)
- ☐ Bacteria Filters – 4/month (A9999)
- ☐ PRN Filters: Air/Intake Filter 1/6 months Particulate Filter 1/month
  White Pollen Filter 2/month Fan Filter 1/6 months

Secondary Settings:

- ☐ Assist Control via Mouthpiece ventilation Vt _____
- ☐ Pressure Control via Mouthpiece Ventilation
  IPAP _____ EPAP _____

Frequency & Usage:

- ☐ Continuous ☐ Nocturnal ☐ PRN
- ☐ Supplemental Oxygen Bleed In
- ☐ Sterile H2O – 31,000mL max/mo (A4217)
- ☐ Non-Invasive Interface (Patient Preference)
  Full Face Mask (A7030) – 1 every 3 months
  Full Face Cushion (A7031) – 1/month
  Nasal Mask (A7034) – 1 every 3 months
  Nasal Pillows/Cushions (A7032/A7022) – 2/month
- ☐ MPV Circuit – 4/month (A4618)

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: _____