



Tracheostomy Care & Aerosol Compressor High Volume Standard Written Order

Fax: 907-561-9221

Phone: 907-561-9220

Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

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

Date of Last Visit: _____

Diagnosis and Code: _____

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

Refer to coverage criteria sheet for all required documentation.

TRACHEOSTOMY CARE SUPPLIES:

- | | |
|---|---|
| ☐ Trach: Size _____ 1 per 3 months | ☐ Cuffed ☐ UnCuffed Part #: _____ |
| ☐ Inner Cannula – 31 per month | ☐ Trach Mask (A7525) – 2 per month |
| ☐ Trach Ties/Collar (A7526) – 31 per month | ☐ Trach Care Kit (A4629) – 31 per month |
| ☐ Passy Muir Valve (L8501) – 1/quarter | ☐ Thermovent T (A7507) – 62 per month |
| ☐ Saline, 5ML (A4216) – 1 box of 100 per quarter | ☐ Cotton Tip Applicators, Sterile (A9999) – 1 box/mo |
| ☐ Gauze – 60/mo | ☐ Other: _____ |

AEROSOL COMPRESSOR:

Equipment:

- ☐ Aerosol Compressor (E0565) ☐ Heater (A9900/A9999)

Supplies:

- | | |
|---|--|
| ☐ Trach Mask (A7525) – 2 per month | ☐ Water Trap, Lg Volume (A7012) – 2 per month |
| ☐ Tubing, Corrugated (A7010) – 1 per 2 months | ☐ Nebulizer Cap, Large Volume (A7007) – 2 per month |
| ☐ Sterile water for Inhalation (A4217) – 31,000 mL/max | ☐ Other: _____ |

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: _____