Cough Stimulating Device Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

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

Refer to coverage criteria sheet for all required documentation.

COUGH STIMULATING DEVICE:

Diagnosis and Code: _____

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

Equipment:

Cough Stimulating Device (E0482)

Mode: ☐ Manual ☐ Auto ☐ Patient Preference **Cough-Trek:** ☐ On ☐ Off ☐ Patient Preference

Setting: Inspiratory Pressure: _____cm H2O Inspiratory Time: _____secs.

Expiratory Pressure: _____cm H2O Expiratory Time: _____secs.

☐ Titrate inspiratory and expiratory pressures to achieve an effective cough

Frequency:

☐ Two (2) times daily and as needed ☐ Other: _____

Interface Method: ☐ Mask (A7020) ☐ Mouthpiece (A7020) ☐ Trach Adapter (A7020) Medicare: 1/mo Medicaid: 1/yr Private: 2/month

Supplies: ☐ Filters (A9900) 4/Month ☐ Other: _____

☐ Battery

MEDICAL NECESSITY INFORMATION: Must also be supported in medical records, if applicable.

1. Does the patient have a neuromuscular disease? ☐ Yes ☐ No
2. Does the condition cause a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions? ☐ Yes ☐ No

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: _____