Tracheostomy Care & Aerosol Compressor High Volume 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

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: _____