RT Medical - Jenny: 615-469-7299 ext 114 RT Medical Fax: 615-469-7596

COUGH ASSIST

STEP 1 | PATIENT INFORMATION

Patient Information:

Patient Name: _____

DOB: _____ Gender: _____ Height/Weight: _____

Patient Phone Number: _____

Patient Primary Insurance: _____ Policy _____

Narrative Diagnosis Descriptions & ICD10 Codes: _____

STEP 2 | PRESCRIPTION/WRITTEN ORDER PRIOR TO DELIVERY

Start Date: _____ Length of Need _____ (99=lifetime)
__ Dispense one cough assist device
__Frequency: 3 sets of 5 cycles BID, TID, As Needed Pressures +/- _____
__ Other: _____

Physician Signature _____ Date_____
Physician Printed Name _____ NPI # _____

I certify the accuracy of this Rx for the cough assist and that I am the physician identified on this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge. The patient record contains the supplementary documentation to substantiate the medical necessity of the cough assist and physician notes will be provided to the authorized cough assist distributor by request. By providing this form to an authorized distributor, I acknowledge that the patient is aware that he or she may be contacted by said distributor for any additional information to process this order.

STEP 3 | CHECK LIST/MEDICAL RECORD REQUIREMENTS*

Please include all the following:

- ☐ Prescription/Written Order Prior to Delivery (This Form)
- ☐ Patient Demographics with insurance information/Face Sheet
- ☐ Medical records that meet documentation requirements/CT Scan for bronchiectasis diagnosis

*The patient's medical record must have well-documented failure of standard treatments to adequately mobilize retained secretions.

*The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity. The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions, and results, past experience with related items, etc.

STEP 4 | FAX

Fax this form and patient demographic sheet which includes insurance information to RT Medical at 615-469-7596