Integrated Respiratory Solutions

191 S Gary Ave, Suite 150 Carol Stream, IL 60188 (630) 582.0202 Fax: (630) 582.3787

Certificate of Medical Necessity – Non-Invasive Pressure Support Ventilator

Beneficiary / Patient Name: _____ **DOB:** _____

Phone: _____ **Mobile:** _____ **Order Date:** _____

Duration of Equipment: ☐ **99 = Lifetime** ☐ _____ **Months**

ICD-10 Diagnosis: ☐ _____ ☐ _____ ☐ _____

Mode of Delivery: **Non-Invasive Ventilator** (E0466) **(**included humidifier (E0562), tubing (A7037), and filters (A7038 / A7039) **Mask** (PAP Circuit – fit for patient comfort)

TRILOGY

NIGHT TIME:

Settings and Modes: **AVAPS-AE Mode** ☐ **Adjustments for Patient Comfort**

Max Pressure: _____ PS Min _____ PS Max _____

EPAP Min _____ EPAP Max _____ Tidal Volume _____

☐ BPM Rate: _____ I Time: _____ OR ☐ Auto BPM Rate

DAY TIME:

☐ **Mouth Piece Ventilation (MPV) Circuit Assist Control Mode:**

I Time: _____ Tidal Volume*: _____ * **Tidal Volume should be 1 ½ times average tidal volume**

ASTRAL

NIGHT TIME:

☐ **IVAPS**: PS Min: _____ PS Max: _____ EPAP: _____ Target PT Rate: _____

VT: _____ Ti Min: _____ Ti Max: _____ ☐ **Titrate to patient comfort**

☐ **PS with safety (VT)**: PS: _____ PS Max: _____ RR: _____ PEEP: _____

Safety VT Target: _____ Ti Min: _____ Ti Max: _____

DAY TIME: ☐ **Mouth Piece Ventilation (MPV) Circuit**

PACV /MVP Mode: Pcontrol: _____ Ti: _____ Tidal Volume: _____

Vent Frequency/Usage: ☐ During Sleep ☐ During day

DOES PATIENT HAVE OXYGEN: ☐ Yes ☐ No

☐ **Oxygen (E1390)** ☐ **Portable Tanks (E0443)** _____ LPM ☐ Nocturnal ☐ During day ☐ Continuous

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Printed Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date:** _____