Integrated Respiratory Solutions

480 W. Lake Street, Suite C Roselle, IL 60172 (630) 582.0202 Fax: (630) 582.3787

Certificate of Medical Necessity – Non Invasive Pressure Support Ventilator

Beneficiary / Patient Name: _____

DOB: _____ **Height:** _____ **Weight:** _____

Physician: _____ **Start of Care:** _____

Duration of Equipment: ☐ Lifetime (99 months) ☐ Other: _____ **Months**

ICD-10 Diagnosis: _____ , _____ , _____

Mode of Delivery: ☐ **Non-Invasive Ventilator** (E0466) **(**included humidifier (E0562), mask (A7034), tubing (A7037), headgear (A7035), and filters (A7038 / A7039)

Settings: **AVAPS-AE Mode**

PS Min _____ PS Max _____ EPAP Min _____ EPAP Max _____VT _____
BPM Rate _____

Frequency/Usage: ☐ During Sleep ☐ During day ☐ Continuous

☐ Oxygen at _____ LPM bleed in via ventilator (E1390)

☐ **Download via DirectView:** ☐ 1& 6 Months or ☐ _____

Additional Information: (attach current medical documentation):

☐ Respiratory Assist Device (RAD) has been tried and found to ineffective for the reasons below. (Check all that apply)

- ☐ Patient could not tolerate RAD.
- ☐ It is unsafe to place on RAD due to recent hospital stay that required mechanical ventilation, required ventilation not available with RAD at home to prevent re-hospitalization.
- ☐ RAD is not controlling patients CO_2 level.

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

Address: _____ **Contact Name:** _____

Phone: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____