HAYEK MEDICAL
A UNITED HAYEK COMPANY

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1-877-895-5583

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HOME CARE ORDER CHECKLIST

DOCUMENTATION AND INSURANCE INFORMATION

REQUIRED

- ☐ *PATIENT DEMOGRAPHICS AND INSURANCE INFO*
- ☐ *PRESCRIPTION FOR BCV*
- ☐ *MEDICAL RECORDS AND CHART NOTES, INCLUDING DIAGNOSES*
  - ☐ *Documentation of Biphasic Cuirass Ventilation order in chart notes, and why.*
  - ☐ *Documentation of recent testing, and other clinical support*
- ☐ *LETTER OF MEDICAL NECESSITY - **Please visit www.hayekmedical.com/lmn***

A letter of medical necessity is needed to support the prescription with the insurance provider. We have several examples based on the patient's general diagnosis listed below. Please Scan the QR Code or enter the URL below. It is recommended that all letters, whether based on our example or not, include the key elements in the Physician Generated LMN segment below. Our Clinical Specialists or Customer Service representatives are always ready to assist. ***www.hayekmedical.com/lmn***

SELECTION APPROPRIATE LMN SAMPLE

Respiratory Failure	*Cardiac/Fontan Failure*	*Respiratory Failure with PAP*	*Cystic Fibrosis*	*Neuromuscular Respiratory Failure*
hayekmedical.com/lmn/rf/	*hayekmedical.com/lmn/cardiac/*	*hayekmedical.com/lmn/rfpap/*	*hayekmedical.com/lmn/cf/*	*hayekmedical.com/lmn/nm/*

PHYSICIAN GENERATED LMN MUST INCLUDE:

- ☐ *Patient, Clinic/Facility and Prescriber Identifying Information*
- ☐ *Patient Condition & Diagnoses Relative to the Prescription*
- ☐ *Reoccurrence of Admission, Emergent Or Unscheduled Clinic Visits Due to Symptoms Treatable With BCV.*
- ☐ *Documentation of Failed Mask Ventilation (If Applicable)*
- ☐ *Why Prescribing BCV (Assertive, Not As A Trial)*
- ☐ *Delineation or Description of Potentials For Poor Outcome Without BCV*
- ☐ *Any Tests (Such As PULSE OX, ABGs, PFTs, CXRs, etc.)*

Physician Prescription Form

1-855-243-8228

1-877-895-5583

Date: _____

Patient Information

Full Name: _____
Last *First* *M.I.*

Date of Birth: _____ Gender: ☐ Male ☐ Female

Patient Height (Inches) _____ **Patient Weight (Lbs)** _____

** Selection of Mode 1 (CNEP) is required when ordering selections 2, 3 or 4 for optimal therapy.**

☐ 1. Biphasic Cuirass Ventilation – Continuous Negative Mode (CNEP)

Inspiratory Pressure:(-)_____cmH_2O

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ 2. Biphasic Cuirass Ventilation – Control Mode

Frequency (rate):_____cpm Inspiratory Pressure:(-)_____cmH_2O Expiratory Pressure:(+)_____cmH_2O I/E Ratio:_____:_____

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ 3. Biphasic Cuirass Ventilation – Respiratory Synchronized Mode

Back Up (rate):_____cpm Inspiratory Pressure:(-)_____cmH_2O Expiratory Pressure:(+)_____cmH_2O

Trigger Source: ☐ **Airway** ☐ **Cuirass** ☐ **Either Airway or Cuirass – titrate for comfort.**

☐ 24 Hours Daily ☐ Nocturnally from_____pm to_____am ☐ Other:_____

☐ 4. Secretion Clearance Mode

Vibration Mode: **Frequency (vibration):_____cpm Inspiratory Pressure: (-)_____cmH_2O Time:_____minutes**

Cough Mode: **Frequency (cough):_____cpm Inspiratory Pressure: (-)_____cmH_2O Expiratory Pressure: (+)_____cmH_2O**

I/E Ratio:_____: _____ Time:_____minutes Repeat Count:_____

☐ 2 times daily ☐ 3 times daily ☐ 4 times daily ☐ Other:_____

Estimated Length of Need (# of Months) ☐ **99 = Lifetime** ☐ **Other Length of Need: _____ (Months)**

☐ **All required supplies for Biphasic Cuirass Ventilation (cuirass shell, cuirass seals, tubing, and straps)**

☐ **Adjust settings to patient comfort/compliance** ☐ **Notify physician of changes**

Notes:

Diagnosis: ☐ **Respiratory Failure** ☐ **ALS** ☐ **SMA** ☐ **COPD** ☐ **MD** ☐ **Chronic Asthma** ☐ **Chronic Bronchitis**
☐ **Cystic Fibrosis** ☐ **Bronchiectasis** ☐ **Post-Fontan** ☐ **Reoccuring Atelectasis** ☐ **CCHS** ☐ **Post Polio**
☐ **Bridge to Lung Transplant** ☐ **Restictive Lung Disease** ☐ **Other:** _____

Referring Physician: _____ Address: _____

Phone: _____ Fax: _____ License #: _____ NPI#: _____

I certify that I am the physician identified on this form. This form has been reviewed and signed by me. I certify that the prescribed services on this form are medically necessary. All information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____