



MEDICARE

Patient Prescription and Certificate of Medical Necessity

When complete, please fax directly to Electromed, Inc. at **888-901-7373**.

Questions? Please call the Reimbursement Department at Electromed, Inc. at **800-462-1045**

Patient Name		Phone
DOB (mm/dd/yyyy)	SSN	Cell/Alternate Phone
Patient Address		

Diagnosis:

Yes	No	Diagnosis: Bronchiectasis AND
Yes	No	Diagnosis confirmed by chest CT scan (attach scan report-required) AND, either
Yes	No	Daily productive cough for at least 6 continuous months (2 clinic notes 6 months apart – include documentation) OR
Yes	No	Frequent (3 or more) annual exacerbations requiring antibiotic therapy (include documentation)

Yes	No	Diagnosis: Cystic Fibrosis	Yes	No	Diagnosis: Neuromuscular
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Clinic notes documenting the tried and failed airway clearance techniques checked below must be attached to the CMN/RX per Medicare requirements for coverage of HFCWO.

Failed AC Techniques:

CPT	Postural Drainage	PEP
Flutter	Acapella	Suctioning
Cough Assist	Breathing Techniques	

Medicare requires that all orders and physician progress notes be signed by the physician.

Rx I certify that this Rx to purchase the SmartVest® Airway Clearance System for lifetime continuous use is accurate: <u>Protocol: Tx/Day-2, Frequencies - 10-16HZ, Minutes/Frequency - 10, Minimum use/day - 15 Minutes. Use settings best tolerated by the patient.</u>			Individualized Protocol (Takes precedence if completed) Tx/Day: Frequencies: Minute/Freq: Minimum use/Day:
Physician Signature—Stamped Signature is not acceptable		Date (mm/dd/yyyy)	
Physician Name			
Physician NPI	Phone		
Contact Person	Phone	Fax	
Physician Address			
Institution			