Atos
Coloplast Group

PRESCRIPTION FORM
For Laryngectomy Supplies and/or Communication Equipment

ATOS MEDICAL • 5000 S. TOWNE DR, SUITE 200 • NEW BERLIN, WI 53151 • T. 800.217.0025 • F. 844.389.4918 • DOCUMENTS.US@ATOSMEDICAL.COM

PATIENT INFO

PATIENT REQUIRED INFORMATION

PATIENT FIRST NAME*	PATIENT LAST NAME*	DATE OF BIRTH (MM/DD/YYYY)*

ICD-10 DIAGNOSIS CODE* (CHOOSE ONE): ☐ Z93.0 Tracheostomy Status ☐ Z43.0 Encounter for Attention to Tracheostomy
☐ _____ ☐ _____

STREET*	CITY*	ST*	ZIP*	LANGUAGE (IF NOT ENGLISH)* ☐ SPANISH ☐ OTHER _____

PATIENT TELEPHONE	PATIENT EMAIL	DATE OF SURGERY	☐ MALE ☐ FEMALE

At patient's request, the caregiver's contact information is included: Name, Phone, Email

CAREGIVER FIRST/LAST NAME	CAREGIVER TELEPHONE	CAREGIVER EMAIL

VOICE REHABILITATION

		VOICE PROSTHESIS 1 - CHOOSE ONE SIZE + ONE LENGTH		VOICE PROSTHESIS 2 - CHOOSE ONE SIZE + ONE LENGTH			
RX	PROVOX VOICE PROSTHESIS	SIZE (FR)	LENGTH (MM)	SIZE (FR)	LENGTH (MM)	QTY	OTHER
RX	☐ Vega [L8509]	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ Vega XtraSeal [L8509]	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ Provox2 [L8509]	22.5	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	22.5	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ ActiValve [L8509]	22.5 ☐Lt ☐Strg ☐XStrg	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5	22.5 ☐Lt ☐Strg ☐XStrg	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5	1/mo	
RX	☐ NiD [L8507]	☐ 17 ☐ 20	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18	☐ 17 ☐ 20	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18	1/mo	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
	☐ Voice Prosthesis Brush OR Flush [L8513]	2/mo	
	☐ Voice Prosthesis Plug [L8511]	1/mo	
	☐ ActiValve Lubricant [A4402]	4oz/mo	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
RX	☐ Capsule [L8512]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	15/mo	
RX	☐ XtraFlange [L8499]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	1/mo	
RX	☐ NiD Dilator [L8514]: ☐ 17Fr ☐ 20Fr	1/mo	

▶ For Voice Prosthesis (VP) Accessories, please INDICATE CURRENT VP TYPE: _____ SIZE: _____ Fr _____mm

RX	PROVOX SPEECH AIDS	QTY	OTHER
	☐ Electrolarynx [L8500]	1	

RX	PROVOX SPEECH AIDS ACCESSORIES	QTY	OTHER
	☐ Electrolarynx Battery [L8505]	1	

PULMONARY REHABILITATION

RX	PROVOX/PROVOX LIFE ADHESIVES/HMES	QTY	OTHER
	☐ Adhesives [A7508]	60/mo	
	☐ Heat and Moisture Exchangers - HMEs [A7507]	60/mo	
RX	☐ Micron HME [A7507]	60/mo	

RX	PROVOX/PROVOX LIFE ATTACHMENTS	QTY	OTHER
RX	☐ LaryTube [A7520]: SIZE _____/_____ TYPE ☐ Std ☐ Fen ☐ Rng SIZE _____/_____ TYPE ☐ Std ☐ Fen ☐ Rng — Provox Life Only ☐ Fen Rng ☐ Fen Rng	1/mo	
RX	☐ LaryButton [A7524]: SIZE ____/_____ SIZE ____/_____	1/mo	
	☐ LaryClip/TubeHolder/Neckband [A7526]	31/mo	
	☐ HME Cassette Adaptor (Provox Only) [A7503]	1/6mos	
	☐ Provox Life Oxygen adaptor [A9999]	30/mo	

RX	PROVOX HME/ADHESIVE ACCESSORIES	QTY	OTHER
	☐ Cleaning Towel [A4245]	1bx/mo	
	☐ Adhesive Remover Wipes [A4456]	50/mo	
	☐ Skin Barrier OR Skin Tac Wipes [A5120]	150/mo	
	☐ Foam Stoma Cover [A4481]	60/mo	
	☐ Double-Sided Foam Disc [A5126]	20/mo	
	☐ Silicone Glue [A4364]	4/mo	
	☐ Shower Aid [A7523]	1/mo	
	☐ TubeBrush [A4626]	2/mo	
	☐ BasePlate Adaptor [E1399]	1/mo	

HANDS-FREE

RX	PROVOX FLEXIVOICE FREEHANDS	QTY	OTHER
RX	☐ Membrane [A7501]: ☐ Light ☐ Med ☐ Strg ☐ XStrg	1/mo	
RX	☐ FreeHands HME [A7507]: ☐ Provox Life ☐ Provox Moist ☐ Provox Flow	60/mo	

RX	PROVOX FREEHANDS ACCESSORIES	QTY	OTHER
RX	☐ HME Cap (Provox Only) [A7503]	1/6mos	
	☐ FreeHands Support Starter Set [E1399]	1/mo	
	☐ FreeHands Support/Adhesive [E1399]	1/mo	

HCP INFO

REQUIRED MEDICAL RECORDS SUBMITTED MUST SUPPORT THE MEDICAL NECESSITY FOR THE PRODUCT(S)

SLP NAME	SLP TELEPHONE	SLP FAX	SLP EMAIL

FACILITY NAME / ADDRESS	NOTES

TREATING PRESCRIBER REQUIRED INFORMATION

TREATING PRESCRIBER NAME*	PRESCRIBER TELEPHONE*
PRESCRIBER NPI	ORDER DATE*
PRESCRIBER SIGNATURE* NO STAMPS ALLOWED	SIGNATURE DATE*

The above information is true, accurate, and complete to the best of my knowledge. I confirm that the patient is/was treated by me, and is able to use the supplies prescribed. I verify that the patient's medical condition requires the supplies prescribed, and that the usage quantities are medically necessary. I will maintain a copy of this order in the patient's file.

This is a prescription form only and will NOT automatically generate an order for shipment. RX VALID 12 MONTHS FROM ORDER DATE ***Required**

Print Form and Sign