

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): ☐ Z43.0 Encounter for Attention to Tracheostomy ☐ Z90.02 Acquired Absence of Larynx ☐ Z93.0 Tracheostomy Status ☐ _____				
	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)		RX	PROVOX VOICE PROSTHESIS	SIZE (FR)	LENGTH (MM)	QTY	OTHER	
	RX	☐ Vega [L8509]	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15		RX	☐ Vega [L8509]	☐ 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		RX	☐ Vega XtraSeal [L8509]	☐ 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		RX	☐ Provox2 [L8509]	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		RX	☐ ActiValve [L8509]	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		RX	☐ NiD [L8507]	☐ 17 ☐ 20	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18	1/mo		
	RX	PROVOX VOICE PROSTHESIS ACCESSORIES			QTY	OTHER	RX	PROVOX VOICE PROSTHESIS ACCESSORIES			QTY	OTHER
		☐ Voice Prosthesis Brush OR Flush [L8513]	2/mo			RX	☐ Capsule [L8512]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	15/mo				
		☐ Voice Prosthesis Plug [L8511]	1/mo			RX	☐ XtraFlange [L8499]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	1/mo				
	☐ ActiValve Lubricant [A4402]	4oz/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	RX	PROVOX SPEECH AIDS ACCESSORIES			QTY	OTHER	
	☐ Electrolarynx [L8500]	1					☐ Electrolarynx Battery [L8505]	1				

PULMONARY REHABILITATION	RX	PROVOX/PROVOX LIFE ADHESIVES/HMES			QTY	OTHER	RX	PROVOX HME/ADHESIVE ACCESSORIES			QTY	OTHER
		☐ Adhesives [A7508]	60/mo					☐ Cleaning Towel [A4245]	1bx/mo			
		☐ Heat and Moisture Exchangers - HMEs [A7507]	60/mo					☐ Adhesive Remover Wipes [A4456]	50/mo			
	RX	☐ Micron HME [A7507]	60/mo					☐ Skin Barrier OR Skin Tac Wipes [A5120]	150/mo			
	RX	PROVOX/PROVOX LIFE ATTACHMENTS			QTY	OTHER		☐ Foam Stoma Cover [A4481]	60/mo			
	RX	☐ LaryTube [A7520]:	1/mo					☐ Double-Sided Foam Disc [A5126]	20/mo			
		SIZE _____ TYPE ☐ Std ☐ Fen ☐ Rng ☐ Fen Rng						☐ Silicone Glue [A4364]	4/mo			
		SIZE _____ TYPE ☐ Std ☐ Fen ☐ Rng ☐ Fen Rng						☐ Shower Aid [A7523]	1/mo			
	RX	☐ LaryButton [A7524]: SIZE _____ SIZE _____	1/mo					☐ TubeBrush [A4626]	2/mo			
		☐ LaryClip/TubeHolder/Neckband [A7526]	31/mo					☐ BasePlate Adaptor [E1399]	1/mo			
	☐ HME Cassette Adaptor (Provox Only) [A7503]	1/6mos										
	☐ Provox Life Oxygen adaptor [A9999]	30/mo										

HANDS-FREE	RX	PROVOX FLEXIVOICE FREEHANDS			QTY	OTHER	RX	PROVOX FREEHANDS ACCESSORIES			QTY	OTHER
	RX	☐ Membrane [A7501]: ☐ Light ☐ Med ☐ Strg ☐ XStrg	1/mo				RX	☐ HME Cap (Provox Only) [A7503]	1/6mos			
	RX	☐ FreeHands HME [A7507]: ☐ Provox Life ☐ Provox Moist ☐ Provox Flow	60/mo					☐ 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