PRESCRIPTION AND DIAGNOSIS FORM

For Communication Equipment and/or Tracheostoma Supplies

This is a prescription form only and will NOT automatically generate an order for shipment

PATIENT INFO

Patient Name*	Patient Phone*	Date of Birth*	☐ Male ☐ Female	Caregiver Name/Phone*
Address*		City*	State*	Zip*
Email*	Insurance Carrier*	Insurance Phone*	Policy#*	

PRESCRIPTION INFORMATION

BREATHING (PULMONARY REHABILITATION)

DAYTIME USE

Provox HME Cassettes	# Cassettes per Month*
☐ XtraMoist HME	☐ 30 ☐ 60 ☐ 90
☐ XtraFlow HME	☐ 30 ☐ 60 ☐ 90
☐ Micron HME	☐ 5 ☐ 30 ☐ 60 ☐ 90

Provox Adhesives	Type	# Adhesives per Month*
☐ FlexiDerm	☐ Rnd ☐ Oval ☐ Plus	☐ 20 ☐ 40 ☐ 60 ☐ 80
☐ OptiDerm	☐ Rnd ☐ Oval ☐ Plus	☐ 20 ☐ 40 ☐ 60 ☐ 80
☐ XtraBase		☐ 20 ☐ 40 ☐ 60 ☐ 80
☐ StabiliBase		☐ 15 ☐ 30 ☐ 45 ☐ 60
☐ StabiliBase OptiDerm		☐ 15 ☐ 30 ☐ 45 ☐ 60

Tracheostoma Support	Type	Size*	Replace Frequency*
☐ Provox LaryButton			/Mos
☐ BM Trach Button			/Mos
☐ Provox LaryTube	☐ Std ☐ Fen ☐ Ring		/Mos
☐ Provox LaryClip			/Mos
☐ Provox TubeHolder			/Mos

NIGHTTIME USE

Provox Luna (Nighttime HME/Adhesive System)	Quantity per Month*
☐ Luna HME	☐ 30 ☐ 60 ☐ 90
☐ Luna Adhesive	☐ 15 ☐ 30 ☐ 45 ☐ 60
☐ Provox Adhesive Strip	☐ 10 ☐ 20 ☐ 30
☐ Luna ShowerAid	pcs

HANDS-FREE

Provox FreeHands FlexiVoice	Replace Frequency*
☐ Set Plus	/Mos
☐ Set	/Mos
☐ Light ☐ Medium ☐ Strong ☐ XtraStrong	/Mos
☐ HME Cap	/Mos

	Quantity per Month*
☐ Arch (5 pcs/box)	box

Provox FreeHands HME Cassettes	# Cassettes per Month*
☐ Moist	☐ 30 ☐ 60
☐ Flow	☐ 30 ☐ 60

Provox FreeHands Support	Replace Frequency*
☐ Starter Set	/Mos
☐ Flat ☐ Medium ☐ Deep	/Mos
☐ Removal Aid (2 pcs)	/Mos

	Quantity per Month*
☐ Support Adhesive	☐ 15 ☐ 30 ☐ 45

SPEAKING (VOICE REHABILITATION)

Voice Prosthesis Model*	Size*			Replace Frequency*
☐ Provox Vega	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	/Mos
☐ Provox Vega XtraSeal	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	/Mos
☐ Provox2			☐ 22.5Fr	/Mos
☐ Provox ActiValve	☐ Lgt	☐ Strg	☐ Xtr Strg	/Mos
☐ Provox NiD	☐ 17Fr	☐ 20Fr		/Mos

Length*

☐ 4mm Vega Only ☐ 4.5mm Provox2/ ActiValve ☐ 6mm ☐ 8mm ☐ 10mm

☐ 12mm NiD Only ☐ 12.5mm N/A NiD ☐ 14mm NiD Only ☐ 15mm ☐ 18mm NiD Only

Other	Type	Quantity per Month*
☐ Electrolarynx		
☐ EL Battery		/Mos

☐ SoniVox Plus Waistband Amplifier ☐ BoomVox

☐ TruTone HandsFree Accessory ☐ SmartCharger

☐ Servox Oral Connector w/Adapter

☐ TruTone Oral Adaptor

CARE (ACCESSORIES) Prescription is required for accessories

Tracheostoma/Laryngectomy Accessories				Quantity per Month*
☐ Provox Cleaning Towel (200 pcs/box)				box
☐ Provox Adhesive Remover Wipes (50 pcs/box)				box
☐ Provox Skin Barrier Wipes (50 pcs/box)				box
☐ Skin Tac (50 pcs/box)				box
☐ Provox Silicone Glue (30mL bottle)				btl
☐ Provox Brush (set of 6 for VPs)	☐ Std	☐ XL		set
☐ Provox TubeBrush (set of 6 for Tube/Button)	☐ 8mm	☐ 12mm		set
☐ Stoma Foam Cover (30 pcs/box)				box
☐ Provox Flush				pcs
☐ Provox ShowerAid				pcs
☐ Provox XtraFlange	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	pcs
☐ Provox Plug ☐ Std	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	pcs
☐ Provox ActiValve Lubricant				pcs
☐ Provox Dilator (NiD Only)	☐ 17Fr	☐ 20Fr		pcs
☐ Provox BasePlate Adaptor				pcs
☐ Provox HME Cassette Adaptor				pcs
☐ Provox Capsule (15 pcs) ☐ 16Fr	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	pcs
☐ Double-sided Foam Discs (20 pcs/box)	☐ Std	☐ Lrg		box
☐ Kapi Gel Spacer **ID** ☐ 8mm ☐ 12mm	**Thick** ☐ 3mm	☐ 5mm		pcs

PHYSICIAN/CLINICIAN USE ONLY

ENTER Z43.0 OR Z93.0 – REQUIRED FOR MEDICARE

Diagnosis* ICD-10 Code	Diagnosis* ICD-10 Code	Diagnosis* ICD-10 Code

# Months Needed* 1-99 mos / 99=Life	Reasons for Medical Necessity

Notes ☐ Do not substitute Provox products with another brand

Date of Surgery	Clinician Name
Clinician Phone	Clinician Email

I certify the medical necessity of this item for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Facility Name and Address	Email	Phone	Fax
	Physician Name*	Physician NPI*	
	Physician Signature* No stamps allowed	Date*	Date Needed (if different than signed date)

Print Form and Sign

* Required

MC1724-THUSENL, 201804

Atos

Atos Medical Inc • 2801 South Moorland Road • New Berlin, WI 53151 USA

Tel 800.217.0025 • Fax 844.389.4918 • info.us@atosmedical.com • www.atosmedical.us

HELPFUL HINTS FOR COMPLETING PRESCRIPTION AND DIAGNOSIS FORM

PATIENT INFORMATION

Everything in this section is important to complete for following up with your patient about an order and for helping to facilitate insurance coverage.

PATIENT INFO

Patient Name*	Patient Phone*	Date of Birth*	☒ Male ☐ Female	Caregiver Name/Phone*
JOHN SMITH	123.456.7890	01/01/1960		JUDY SMITH / 123.456.0987

Address*	City*	State*	Zip*
123 MAIN STREET	ANYWHERE	WI	53000

Email*	Insurance Carrier*	Insurance Phone*	Policy#*
JOHNSMITH@GMAIL.COM	UNITED HEALTHCARE	800.123.4567	987654321

PRESCRIPTION INFORMATION

Quantity: Always indicate the amount needed, otherwise the prescription is only good for one time.

Size: Be sure to include any size information for proper fit.

All Voice Prosthesis Sections: Be sure to complete all sections, including:
- Model
- Size
- Replace Frequency
- Length

PRESCRIPTION INFORMATION

BREATHING (PULMONARY REHABILITATION)

DAYTIME USE

Provox HME Cassettes — # Cassettes per Month*

☒ XtraMoist HME	☐ 30 ☒ 60 ☐ 90	
☒ XtraFlow HME	☐ 30 ☒ 60 ☐ 90	
☒ Micron HME	☐ 5 ☐ 30 ☒ 60 ☐ 90	

Provox Adhesives	**Type**	**# Adhesives per Month***
☒ FlexiDerm	☐ Rnd ☒ Oval ☐ Plus	☐ 20 ☐ 40 ☒ 60 ☐ 80
☒ OptiDerm	☐ Rnd ☒ Oval ☐ Plus	☐ 20 ☐ 40 ☒ 60 ☐ 80
☐ XtraBase		☐ 20 ☐ 40 ☐ 60 ☐ 80
☐ StabiliBase		☐ 15 ☐ 30 ☐ 45 ☐ 60
☒ StabiliBase OptiDerm		☐ 15 ☒ 30 ☐ 45 ☐ 60

Tracheostoma Support	**Type**	**Size***	**Replace Frequency***
☐ Provox LaryButton			/Mos
☐ BM Trach Button			/Mos
☒ Provox LaryTube	☒ Std ☐ Fen ☐ Ring	9/27	1 /Mos
☐ Provox LaryClip			/Mos
☒ Provox TubeHolder			1 /Mos

NIGHTTIME USE

Provox Luna (Nighttime HME/Adhesive System)	**Quantity per Month***
☐ Luna HME	☒ 30 ☐ 60 ☐ 90
☐ Luna Adhesive	☐ 15 ☒ 30 ☐ 45 ☐ 60
☐ Provox Adhesive Strip	☐ 10 ☐ 20 ☐ 30
☐ Luna ShowerAid	pcs

HANDS-FREE

Provox FreeHands FlexiVoice	**Replace Frequency***
☒ Set Plus	1 /Mos
☐ Set	/Mos
☐ Light ☐ Medium ☐ Strong ☐ XtraStrong	/Mos
☐ HME Cap	/Mos

Quantity per Month*

☐ Arch (5 pcs/box) — box

Provox FreeHands HME Cassettes	**# Cassettes per Month***
☒ Moist	☐ 30 ☒ 60
☒ Flow	☐ 30 ☒ 60

Provox FreeHands Support	**Replace Frequency***
☐ Starter Set	/Mos
☐ Flat ☐ Medium ☐ Deep	/Mos
☐ Removal Aid (2 pcs)	/Mos

Quantity per Month*

☐ Support Adhesive — ☐ 15 ☐ 30 ☐ 45

SPEAKING (VOICE REHABILITATION)

Voice Prosthesis Model*	**Size***	**Replace Frequency***
☒ Provox Vega	☐ 17Fr ☒ 20Fr ☐ 22.5Fr	2 /Mos
☐ Provox Vega XtraSeal	☐ 17Fr ☐ 20Fr ☐ 22.5Fr	/Mos
☐ Provox2	☐ 22.5Fr	/Mos
☐ Provox ActiValve	☐ Lgt ☐ Strg ☐ Xtr Strg	/Mos
☐ Provox NiD	☐ 17Fr ☐ 20Fr	/Mos

Length*

☐ 4mm Vega Only	☐ 4.5mm Provox2/ ActiValve	☒ 6mm	☐ 8mm	☐ 10mm
☐ 12mm NiD Only	☐ 12.5mm N/A NiD	☐ 14mm NiD Only	☐ 15mm	☐ 18mm NiD Only

Other	**Type**	**Quantity per Month***
☒ Electrolarynx	TRUTONE	
☐ EL Battery		/Mos

☐ SoniVox Plus Waistband Amplifier ☐ BoomVox

☐ TruTone HandsFree Accessory ☐ SmartCharger

☐ Servox Oral Connector w/Adapter

☐ TruTone Oral Adaptor

CARE (ACCESSORIES) Prescription is required for accessories

Tracheostoma/Laryngectomy Accessories					**Quantity per Month***
☒ Provox Cleaning Towel (200 pcs/box)					1 box
☒ Provox Adhesive Remover Wipes (50 pcs/box)					1 box
☒ Provox Skin Barrier Wipes (50 pcs/box)					1 box
☒ Skin Tac (50 pcs/box)					1 box
☐ Provox Silicone Glue (30mL bottle)					btl
☒ Provox Brush (set of 6 for VPs)			☐ Std	☐ XL	1 set
☐ Provox TubeBrush (set of 6 for Tube/Button)			☐ 8mm	☐ 12mm	set
☐ Stoma Foam Cover (30 pcs/box)					box
☒ Provox Flush					1 pcs
☒ Provox ShowerAid					1 pcs
☐ Provox XtraFlange		☐ 17Fr	☐ 20Fr	☐ 22.5Fr	pcs
☒ Provox Plug	☐ Std	☐ 17Fr	☒ 20Fr	☐ 22.5Fr	1 pcs
☐ Provox ActiValve Lubricant					pcs
☐ Provox Dilator (NiD Only)			☐ 17Fr	☐ 20Fr	pcs
☐ Provox BasePlate Adaptor					pcs
☐ Provox HME Cassette Adaptor					pcs
☐ Provox Capsule (15 pcs)	☐ 16Fr	☐ 17Fr	☐ 20Fr	☐ 22.5Fr	pcs
☐ Double-sided Foam Discs (20 pcs/box)			☐ Std	☐ Lrg	box
☐ Kapi Gel Spacer **ID** ☐ 8mm ☐ 12mm **Thick** ☐ 3mm ☐ 5mm					pcs

PHYSICIAN/CLINICIAN USE ONLY

Diagnosis Codes: ICD-10 Diagnosis Codes are required

Medicare Beneficiaries: must have one of the following diagnosis for coverage of tracheostomy supplies:
- Z93.0 Tracheostomy status
- Z43.0 Encounter for attention to tracheostomy

 # Months Needed: Always indicate the number of months needed (99=Life) or the prescription can only be used one time.

Medical Professional Name, Signature and NPI: Printed name and NPI required for prescribing medical professional along with signature and date. No stamps allowed. Signature of Clinician is currently not acceptable for Medicare or insurance coverage guidelines.

Date: Date is required.

PHYSICIAN/CLINICIAN USE ONLY

ENTER Z43.0 OR Z93.0 – REQUIRED FOR MEDICARE

Diagnosis* ICD-10 Code	Diagnosis* ICD-10 Code	Diagnosis* ICD-10 Code
Z93.0	Z43.0	

# Months Needed* 1-99 mos / 99=Life	Reasons for Medical Necessity
99	TOTAL LARYNGECTOMY PULMONARY HEALTH AND VOICE RESTORATION

Notes ☐ Do not substitute Provox products with another brand

Date of Surgery	Clinician Name
05.19.17	MARY JONES

Clinician Phone	Clinician Email
234.567.8901	MARYJONES@UH.COM

I certify the medical necessity of this item for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Facility Name and Address	Email	Phone	Fax
UNIVERSITY HOSPITAL 2345 MEDICAL BOULEVARD ANYWHERE, WI 53000	ROBERTCONNOR@UH.COM	234.567.8902	234.567.8903

Physician Name*	Physician NPI*
DR. ROBERT CONNOR	1234567890

Physician Signature* No stamps allowed	Date*	Date Needed (if different than signed date)
Robert Connor, MD	05.05.17	05.19.17

PLEASE NOTE: This example represents a selection of products a laryngectomy patient could typically use each year. When completing, please include **ALL** products your patient might need throughout the life of the prescription form as it will save significant time and effort of obtaining subsequent prescriptions and getting reimbursement checked and approved. **Remember, this is a prescription form only and will NOT automatically generate an order.**