PRO-AIR
Medical Supply & Equipment

Phone: (989) 355-1601 / 1-844-445-1122
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Detailed Written Order for NON-Invasive Ventilation Order Date: ___________________

Patient Name: ____ DOB: ______________________

Address: ____ Phone #: __________________

Duration of Need: ____________ (0-99 months) 99-Lifetime Height: _______________ Weight: ______________

Primary Diagnosis: ☐

Must Have Secondary Diagnosis. Needs to be #1 OR #2. (See Below)

Chronic Respiratory Failure (J96.10) consequent to severe chronic obstructive pulmonary disease (COPD) (J44.9). Supporting documentation: Attach copy of one or more of the following along with **F2F encounter**:

- ABG w/PaCO2 ≥52 mmHg within 6 months? _______mmHg on __________ (date)
- Or FEV1 ≤ 50% of predicted. _______________ Yes __________ No

AND

1. Two or more respiratory-related hospital admissions/re-admissions within the past 12 months. _____________ Yes __________ No

OR

2. One of the following along with F2F encounter:

Neuromuscular Disease	**ICD-10 Code**	**Restrictive Thoracic Disorder**	**ICD-10 Code**
ALS	☐ G12.21	Pulmonary Thoracic Disorder	☐ ____________
Diaphragm Paralysis	☐ J38.00	Obesity Hypoventilation Syndrome	☐ E66.2
Muscular Dystrophy	☐ G71.0	Interstitial Lung Disease	☐ J84.9
Spinal Cord Injury	☐ ______________	Scoliosis	☐ M41
____________________________	☐ ______________	____________________________	☐ ____________

*** The examples above are not inclusive.** Please use whatever conditions are appropriate for your patient.

Supporting documentation for the above neuromuscular/restrictive states: **One** of the following:

- Nocturnal Oxygen Desaturation (w/SPO2 < 88% for >5 cumulative minutes on Room Air)
- Maximum Inspiratory Pressure of 50 cmH20
- Forced Vital Capacity (FVC 50% of predicted)

☐ **Clinical notes state the severity of the condition?** ☐ **Yes** ☐ **No**

☐ **Interruption of failure of ventilator support would quickly lead to hospital readmission and continued use of a ventilator is highly recommended?** ☐ **Yes** ☐ **No**

****Attn: Some insurances require this. Medicare and Medicaid do not at this time.**

Home BiPAP/VPAP has been considered and ruled out:

☐ Patient required more than intermittent of Nocturnal ventilation support. (example: needs continuous use or mouthpiece ventilation for daytime use) ☐ **Yes** ☐ **No**

☐ The Bi-level Device is not tolerated and proven to be ineffective. ☐ **Yes** ☐ **No**

☐ The severity of condition is life threatening and has progressed where BiPAP cannot effectively treat the condition. ☐ **Yes** ☐ **No**

☐ Link Provider to Airview

Ordering Provider Signature: ____ **Date:** _______________

Printed Provider Name: ____ **NPI:** ______________________