PRESCRIPTION / ORDER FORM - VitalCough® System

Patient Name: _____
(Required - please print) First Middle Last

Birth Date: ____ / ____ / ____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Primary Insurance & ID#: _____

Secondary Insurance & ID#: _____

Facility Contact
Person: _____
Phone: _____
E-mail: _____
Following Physician/PCP: _____
Phone: _____
E-mail: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐H ☐C ☐W Alt Phone: _____ ☐H ☐C ☐W E-mail: _____

Date patient last seen: _____ Is the patient currently in the hospital? ☐N ☐Y Discharge Date: _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

☐ Mouthpiece ☐ Tracheostomy ☐ Mask (please select size below)
☐ Infant ☐ Child ☐ Adult Small ☐ Adult Medium ☐ Adult Large

Relevant Medical History (Check all applicable boxes below)

*Please provide proper documentation from the patient's medical record which supports any of the relevant medical history indicated below.

- ☐ Impairment of the chest wall
- ☐ Diaphragm impairment
- ☐ Inability to cough or clear secretions
- ☐ Diminished bulbar function
- ☐ Hx of aspiration of saliva, food or liquids
- ☐ Frequent respiratory infections
- ☐ Decline in pulmonary function
- ☐ Mechanical ventilator
- ☐ ER visits due to pulmonary exacerbation
- ☐ Hospitalizations due to pulmonary exacerbation
- ☐ Tracheostomy
- ☐ Atelectasis
- ☐ Mucus plugs

Please indicate methods of Airway Clearance Patient has tried or currently using (check all applicable boxes below):

- ☐ CPT (Manual or Percussor)
- ☐ Flutter Device
- ☐ Cannot use other methods
- ☐ Nebulizers / Inhalers
- ☐ High Frequency Chest Wall Oscillation (HFCWO)
- ☐ Other: _____
- ☐ PEP

Comments:

Clinic Information: Fac#
Clinic Name:
Address:
City: State: Zip:
Phone: Fax:

1. _____
Signature Date (Required - MM/DD/YY)

2. _____
Prescriber's Signature (Required - no stamped signatures accepted)

3. _____
Print Prescriber's First and Last Name (Required)

4. _____
NPI Number (Required)

Please include documentation of a Face to Face encounter with the patient for a medical condition that supports the need for the device. This is required before device shipment.

℞ **VitalCough® System**

Primary Diagnosis _____
Primary Diagnosis Code _____
Secondary Diagnosis _____
Secondary Diagnosis Code _____

PROTOCOL

Please Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.

	Standard	Custom
Treatments per day	2	
Inhale Pressure	0 to 50 cm H2O	
Exhale pressure	-15 to -50 cm H2O	
Length of Need	99 months = Lifetime	

Other Protocol Notes:

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records

Hill-Rom Enhancing outcomes for patients and their caregivers.

Advanced Respiratory, Inc.,
A Hill-Rom Company

1020 West County Road F
St. Paul, Minnesota 55126
P: **800-426-4224** or 651-490-1468
F: 866-643-5787
respiratorycare.hill-rom.com

TERMS, CONDITIONS AND RESPONSIBILITY FORM - VitalCough® System

Advanced Respiratory, Inc. ("ARI"), a Hill-Rom company, is being asked to supply VitalCough® System. If you have questions about this form, please contact ARI's Customer Service team at **1-800-426-4224** before signing.

PATIENT/CUSTOMER NAME: _____ **PATIENT ACCOUNT NUMBER:** _____

1. HEALTH INFORMATION PRIVACY

I authorize all persons (including ARI) with medical or other information about me to release such information to health insurers and health care programs related to eligibility, claims and payments for products or services provided to me by ARI and health care operations. I acknowledge that I received ARI's Notice of Privacy Practices, which further describes how ARI may use and disclose my health information, as well as my rights under certain privacy laws and is also available at www.hill-rom.com.

2. FINANCIAL RESPONSIBILITY

I understand that ARI will work with me to obtain reimbursement from my insurance carrier(s) and has programs to support patients through the reimbursement process, including providing appeal assistance. I further understand that ARI has interest-free payment plans and patient financial assistance for those patients who qualify financially and have an established need to receive medically necessary medical services. I acknowledge that I am able to and will promptly return my device, at no cost, if ARI is unable to obtain reimbursement from my insurance carrier(s) and I do not make other financial arrangements to pay ARI for the equipment.

I am responsible for any amounts not covered by my insurance carrier(s), including any applicable co-payments and deductibles. I also agree to cooperate with the reimbursement process and assist in any appeal.

It is my responsibility to return all rental equipment to ARI if: 1) I stop using the equipment; 2) the medical order for the equipment ends or is discontinued; 3) I fail to make acceptable financial arrangements for any amounts not covered by my insurance carrier(s); or 4) ARI reasonably requests that I return the equipment.

3. ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF THIRD PARTY PAYMENT

I authorize ARI to submit insurance carrier claims on my behalf for the products and services provided by ARI. I authorize payment of medical benefits be made directly to ARI for VitalCough® System provided to me by ARI.

ARI accepts assignment unless ARI enters into a separate written and signed agreement with me that specifically states that ARI is not accepting assignment.

By signing this, I agree to all of the terms and conditions listed.

Signature of Patient or Patient's Authorized Representative:

X _____ Date: _____
Signature (MM/DD/YY)

Authorized Representative's Relationship to Patient and Address (Required when Authorized Representative is signing):

_____ _____
Relationship Address

Check reason patient unable to sign:

☐ Patient/customer is under 18.

☐ Patient/customer is physically or cognitively unable to sign on their own behalf.

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TERMS, CONDITIONS AND RESPONSIBILITY FORM

By accepting this product and any replacement products which may be provided, you (patient/caregiver/legal guardian) are representing that you understand and acknowledge that your insurance carrier(s), including certain government insurance programs, may eventually require ownership of the product to be transferred to the insurance program from which payment was received. In these and other cases where you do not own the equipment, ARI may need to (re)enter the home to perform certain tasks related to title transfer activities. By accepting the product, you agree to comply with all such requirements and to grant access to the home, as needed. Please contact your insurance carrier(s) if you have questions regarding transfer of product ownership.

ADDITIONAL NOTIFICATIONS FOR RESIDENTS OF MAINE

The person signing this authorization may receive a copy of this authorization.

A patient may refuse authorization to disclose some or all health care information, but that refusal may result in improper diagnosis or treatment, or denial of coverage of a claim for health benefits or other insurance. This authorization may be revoked at any time, subject to the right of the person acting in reliance on the authorization to use such revocation as the basis for denial of coverage.

ADDITONAL NOTIFICATIONS FOR RESIDENTS OF RHODE ISLAND

The person signing this authorization may receive a copy of this authorization.

Consent may be withdrawn at any time except where an authorization is executed in connection with a claim for benefits, and if so the authorization is valid for the duration of the claim.

Please fax the front of this form to: 1-866-643-5787