The Vest® Airway Clearance System

Checklist and Fax Cover Sheet – 800.870.8452

To:		Facility Name:	
Fax:			
Date:		Sender Name:	
Re:	Prescription for The Vest® Airway Clearance System	Sender Phone:	
		Sender Email:	

PLEASE INCLUDE THE FOLLOWING:

- ☐ **Physician's Signed and Dated Prescription including NPI number (Required prior to delivery)**
- ☐ **When required by the payer, documentation of a Face to Face Encounter with the patient within the last 6 months documenting the need for the product ordered (Required prior to delivery)**
- ☐ **Patient Demographic/Face Sheet**
- ☐ **Copy of Patient's Insurance Card(s) (if available)**
- ☐ **Patient Signed TCR (Terms Conditions and Responsibility)**
- ☐ **Hospital Discharge Summary, if applicable**
- ☐ **Medical Records for the past 6-12 months**
  - ☐ **Include other airway clearance therapies tried and/or considered**
  - ☐ **Include reason(s) other airway clearance therapies were inappropriate, contraindicated or failed**
- ☐ **Also include for <u>BRONCHIECTASIS</u> patients:**
  - ☐ **Chest CT Imaging report confirming diagnosis <u>OR</u> Statement in Medical Record**
  - ☐ **Documentation in medical record of daily productive cough for at least 6 continuous months <u>OR</u> 3 or more exacerbations within the past year requiring antibiotic therapy**

QUESTIONS? Please call Hill-Rom, Respiratory Care Division at 800.426.4224.

COMMENTS: