PRESCRIPTION / ORDER FORM - The VisiVest™ Airway Clearance System

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

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

_____
Street City State Zip

Case Manager: _____
Phone: _____
E-mail: _____
Hospital Room#: _____
Discharge Date: _____

Primary Insurance & ID#: _____ Secondary Insurance & ID#: _____

Patient Contact Name: _____ Relationship to Patient: _____

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

Chest Measurement: _____ Garment Style: FULL VEST (Color: _____) / WRAP VEST / CHEST VEST

Following Physician/PCP: _____ Phone: _____ E -mail: _____

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)

1. ☐ Y ☐ N Have alternative airway clearance techniques been tried and failed?

Please indicate methods of airway clearance patient has tried and failed (check all applicable boxes below):
☐ CPT (manual or percussor) ☐ Oscillating PEP ☐ PEP ☐ Other ☐ Cannot use other methods

Check all reasons why the above therapy failed or is contraindicated or inappropriate for this patient:
☐ Physical limitations of caregiver ☐ Feeding tubes ☐ Unable to form mouth seal ☐ Severe arthritis, osteoporosis
☐ Gastroesophageal reflux (GERD) ☐ Aspiration risk ☐ Insufficient expiratory force ☐ Did not mobilize secretions
☐ Spasticity/contractures ☐ Kyphosis/scoliosis ☐ Artificial airway ☐ Young age
☐ Resistance to therapy ☐ Cognitive level ☐ Unable to tolerate positioning/percussion

2. ☐ Y ☐ N Has there been daily productive cough for at least 6 months?

3. Relevant medical history in past year (check all applicable boxes below):
☐ History of respiratory infections ☐ Hospitalizations due to pulmonary exacerbation ☐ Sputum cultured positive for resistant bacteria
☐ Atelectasis ☐ ER visits due to pulmonary exacerbation ☐ More than 2 exacerbations requiring antibiotic therapy in the last year:
☐ Mucus plugs ☐ Decline in pulmonary function ☐ IV antibiotics ☐ Oral antibiotics

4. For Bronchiectasis patient, please check Yes or No to the following question:
☐ Y ☐ N Has there been a CT scan confirming Bronchiectasis diagnosis? If Yes, please attach required report.

Hospital Information: Fac#
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.

℞ The VisiVest™ Airway Clearance 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	
Minutes per Treatment	20	
Frequencies	6-15	
Minimum Minutes of Use per Day	10	
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

Offered by Advanced Respiratory Inc., a Hill-Rom Company, 1020 West County Road F, St. Paul, MN 55126, Phone: 1.800.426.4224 www.respiratorycare.hill-rom.com
Revised 11/2016

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 - The Vest® System

Advanced Respiratory, Inc. ("ARI"), a Hill-Rom company, is being asked to supply The Vest® 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 understand that data relating to my usage of The Vest® System may be accessed, used, or disclosed to ARI and my healthcare provider(s) in order to coordinate my care and treatment. De-identified data regarding The Vest® System usage may be aggregated and reviewed in order to provide treatment benchmarking information to ARI and my healthcare team. 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 The Vest® 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

REORDER FORM
The VisiVest™ Airway Clearance System

Please fax this completed reorder form to 800-870-8452.
If you have any questions, please call Account Services at 800-426-4224.

To receive more order pads, please complete these 3 steps:

1. Review the information about your facility printed below. If corrections need to be made, clearly mark those in the spaces indicated below.

Hospital Name: Phone:
Address: Fax:

Requested Changes:

Hospital Name: _____

Address: _____
Street

_____
City State Zip

Phone: _____ Fax: _____

PROTOCOL

	Default	Requested Change
Treatments per Day	2	
Minutes per Treatment	20	
Frequencies	6-15	
Minimum Minutes of Use per Day	10	

2. Indicate the number of The VisiVest™ Hospital to Home order pads you need. Each order pad contains 25 order forms.
   ☐ One ☐ Two ☐ Three

3. Fax this reorder form to Account Services at 800-870-8452.

The new order pads will be mailed to the address that appears above.
Please allow 7 business days for delivery.
If copies are needed in the interim, please call Account Services at 800-426-4224.

COMPLETED BY: _____ PHONE: _____
(Please print) First Last