



The VitalCough® System
Checklist and Fax Cover Sheet – 800.870.8452



To:		Facility Name:	
Fax:			
Date:		Sender Name:	
Re:	Prescription for The VitalCough® 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 documentation of significant impairment of the chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions**

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

COMMENTS: