028363

Hastings Home Health Center Cleveland
15210 Industrial Parkway
Cleveland, OH 44135-3308
216-898-3300

Statement of Medical Necessity

Patient Name:
Address:
City/St/Zip:
Phone:

Start of Care:
MRN:
DOB:
Gender:

Diagnosis #1:
Diagnosis #2:
Diagnosis #3:
Diagnosis #4:

Date Last Seen:
Prognosis:
Length of Need:
Access:

This is to certify that the below listed items were ordered on: / /

	Product Description	Quantity	Frequency
E0600	SUCTION PUMP, PORTABLE OR STATIONARY	1	

Statement of Medical Necessity:

<> PLEASE CONFIRM THAT THE PATIENT'S MEDICAL RECORD CONTAINS SUPPORTING DOCUMENTATION FOR
THE AFFIRMATIVE RESPONSES BELOW <>

[ ] YES [ ] NO PATIENT REQUIRES GASTRIC SUCTIONING.

[ ] YES [ ] NO PATIENT HAS DIFFICULTY RAISING AND CLEARING SECRETIONS, REQUIRING A RESPIRATORY
SUCTION PUMP SECONDARY TO ONE OR MORE OF THE FOLLOWING:
(check all that apply)
[ ] CANCER OR SURGERY OF THE THROAT OR MOUTH
[ ] DYSFUNCTION OF THE SWALLOWING MUSCLES
[ ] UNCONSCIOUSNESS OR OBTUNDED STATE
[ ] TRACHEOSTOMY (V44.0, V55.0)

ACCESSORIES USED WITH SUCTION PUMP:
[ ] A4624 - SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED
[ ] TRACHEOSTOMY SUCTIONING_____ 90/MO OR _____/MO
[ ] OROPHARYNGEAL SUCTIONING_____12/MO OR _____ /MO
[ ] A4605 - SUCTION CATHETER, CLOSED_____31/MO OR _____ /MO
[ ] A7000 - CANISTER, DISPOSABLE_____ 4/YR OR _____ /MO
[ ] A7001 - CANISTER, NON-DISPOSABLE_____1/YR OR _____ /MO
[ ] A7002 - SUCTION TUBING_____12/YR OR _____/MO

Physician's Certificate:

I certify / recertify that the above listed products / services are Medically Necessary and that this patient is under my care.

Physician's Signature: _____ **UPIN:**

Date: _____

Date Printed: 09/07/2016