

Patient Information				Order Date	
Last Name		First Name		M <input type="checkbox"/>	F <input type="checkbox"/>
Medical Record #		Phone		Date of Birth	
Street		City		State	Zip
Primary Insurance			Secondary Insurance		
Contact Name			Primary Language		
Alt Phone			Email		
Healthcare Facility			Phone		
Fax			Anticipated 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)

Rx

Type	Description	HCPCS	Qty	Length of Time
MIE Therapy Device	BiWaze™ Cough System	E0482		<input type="checkbox"/> Lifetime (99) <input type="checkbox"/> Other: _____
Patient Circuit Interface	<input type="checkbox"/> Mouthpiece <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Mask Circle Mask Size: Pediatric Adult Small Adult Medium Adult Large	A7020		<input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____

Protocol: The standard protocol will be followed if any or all sections of the custom protocol are blank. Settings may be adjusted to patient comfort and/or with a peak cough flow goal >160 lpm. Auscultation of the upper airway may be performed to evaluate upper airway stability in patients with bulbar syndrome.

	Standard	Custom
Treatments/day	2	
Inhale/Exhale Pressure	(+/-) 5 – 70cm h ₂ O	
Pause Pressure	1 - 15 cm h ₂ O	
Inhale/exhale/pause time	0 – 5 seconds	
Comfort settings (Inspiratory trigger, advanced settings, flow)	Adjust to patient comfort	
Oscillation settings (frequency and amplitude)	Adjust to patient comfort	

Diagnosis: List all primary, secondary, and underlying diagnosis that apply

Diagnosis	Code	Diagnosis	Code
1.		3.	
2.		4.	

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for the BiWaze™ Airway Clearance System and the patient circuit interface, which according to my professional judgement, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of MI-E therapy and I agree to provide such documentation upon request. A copy of this order will be retained as part of the patient's medical record.

Prescriber's Signature: _____ Date: _____
(Original signature and date required. Stamped signature and date not accepted.)

Prescriber's Printed Name: _____ NPI: _____

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