



Advanced Respiratory
 1020 West County Road F
 St. Paul, Minnesota 55126
 P. 800-426-4224 or 651-490-1468
 F. 877-368-5081 or 651-234-1209
www.thevest.com

**Medical Necessity Checklist/
 Physician Statement of Medical Necessity**

Please retain a copy of this form for the patient's medical record and fax a copy to 800-870-8452.

Patient: _____

Facility: _____

Birthdate: _____

Physician: _____

Diagnosis: _____

Facility Phone: _____

Facility Address: _____

Check all appropriate boxes to support medical necessity of The Vest® for this patient. This will be submitted to the insurance payer. All sections below (A, B and C) must be completed by the appropriate Health Care Practitioner.

A. Failure/Contraindication of other airway clearance methods (Completion of 1 and 2 Required)

check all applicable boxes below:

1. Indicate methods of Airway Clearance Patient has tried and circle the result for these methods:

- CPT (manual or percussor) **Circle Result:** Not effective / Did not tolerate
- FLUTTER® **Circle Result:** Not effective / Did not tolerate
- PEP **Circle Result:** Not effective / Did not tolerate
- acapella® **Circle Result:** Not effective / Did not tolerate
- other: _____ **Circle Result:** Not effective / Did not tolerate
- Patient cannot use other methods of airway clearance therapy.

2. Check all reasons why therapy failed or is contraindicated or inappropriate for this patient:

- No caregiver to provide therapy
- Physical limitations of caregiver
- Patient unable to tolerate positioning
- Gastroesophageal reflux (GERD)
- Aspiration risk
- Kyphosis/scoliosis
- Spasticity/contractures
- Inadequate time for complete therapies
- Feeding tubes
- Unable to tolerate percussion
- Severe arthritis, osteoporosis
- Cognitive level
- Unable to form mouth seal
- Insufficient expiratory force
- Young age
- Artificial airway
- Did not mobilize secretions
- Resistance to therapy

B. Relevant medical history in past year (Completion Required): *check all applicable boxes below:*

- History of respiratory infections
- Hospitalizations due to pulmonary exacerbation
- ER visits due to pulmonary exacerbation
- IV antibiotics for respiratory infection
- Oral antibiotics for respiratory infection
- Sputum cultured positive for resistant bacteria
- Decline in pulmonary function
- Atelectasis
- Mucus plugs

C. Notes/Comments to Support Medical Necessity (Completion Required):

I hereby certify that: 1) I am supervising the plan of care for this patient; 2) the statements marked above are true, accurate, and complete to the best of my knowledge; and 3) the patient's medical record contains information to support the medical necessity for this product and to substantiate the information noted above.

Printed Prescriber Name: _____

NPI: _____

Prescriber Signature: _____

Date signed: _____