



Ventilator

HCPCS E0465/E0466



Name:
Address:
Phone/Email:
Fax:

Non-Invasive Ventilation Prescription

Patient Information		
Name:		Date:
DOB:	MRN:	Length of Need:
Primary Dx:		Secondary Dx:
Please attach patient demographics, copy of insurance card & additional documentation as required.		
V*Home Ventilator ☐ Check to prescribe*		
Ventilation	Notes:	
☐ Volume Targeted Ventilation	Hours of Use: ☐ 8 – 24 Hours ☐ Cont. ☐ Other: Interface: ☐ Mask ☐ Other: Mode: ☐ Vol. Targeted-PS ☐ Vol. Targeted-PC ☐ Vol. Targeted-PS w/ IntelliPAP™ ☐ Vol. Targeted-PC w/ IntelliPAP™ Settings: ☐ Titrate To Optimal Patient Response ☐ MIN PS/PC: ☐ MAX PS/PC: ☐ PEEP:* ☐ MIN PEEP: ☐ MAX PEEP: ☐ Ti: ☐ Other: ☐ Breath Rate: ☐ Tidal Volume: <i>*If IntelliPAP is set to ON, PEEP is replaced by MIN PEEP and MAX PEEP.</i>	
☐ High Flow Therapy*	Hours of Use: Interface: ☐ High Flow Cannula ☐ Other: Settings: ☐ Oxygen LPM: ☐ High Flow Liter Flow: <i>*High Flow therapy is only accessible when SIMV-Pressure, SIMV-Volume mode or Vol. Targeted-SIMV is selected.</i>	
☐ Mouthpiece Ventilation	Hours of Use: Interface: ☐ Patient Comfort ☐ Other: Mode: ☐ AC-Pressure ☐ AC-Volume Settings: ☐ Titrate Patient Response and/or ☐ Tidal Volume: or ☐ Pressure: ☐ Flow Trigger:	
☐ Custom Prescription	Hours of Use: ☐ 8 – 24 Hours ☐ Cont. ☐ Other: Interface: ☐ Mask ☐ Other: Mode: Settings:	
Additional Ventilation Prescriptions/Supplies: ☐ Heated Humidifier with all required supplies ☐ Heat-Moisture Exchanger (HME) ☐ Circuit ☐ Bacteria Filters ☐ Air and Fan Filters ☐ Patient is wheelchair dependent and requires a second ventilator (one mounted to wheelchair for daytime mobility, and one bedside for nocturnal use). Provide detail:		

Prescribing Physician		
Name:		Signature:
NPI:	Phone:	Date:



Ventilator

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Invasive Ventilation Prescription

Patient Information

Name:		Date:	
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Primary Dx:		Secondary Dx:	

Please attach patient demographics, copy of insurance card & additional documentation as required.

V*Home Ventilator ☐ Check to prescribe*

Ventilation

☐ Invasive Ventilation

Notes:

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous

Interface: ☐ Trach ☐ Other:

Mode: ☐ AC-Pressure ☐ AC-Volume

☐ SIMV-Pressure ☐ SIMV-Volume

☐ Vol. Targeted-PS

☐ Vol. Targeted-PC

☐ Vol. Targeted-SIMV

Settings: ☐ Titrate To Optimal Patient Response and/or

☐ MIN PS/PC:

☐ MAX PS/PC:

☐ Tidal Volume:

☐ BR:

☐ Ti:

☐ PEEP:

☐ Pres. Control:

☐ Pres. Support:

☐ PC Flow Term:

☐ Rise Time:

☐ Sigh:

☐ Flow Trigger:

☐ Flow Cycle:

☐ Time Cycle:

☐ Apnea Rate:

☐ High Flow Therapy*

Hours of Use:

Interface: ☐ High Flow Cannula ☐ Other:

Settings: ☐ Oxygen LPM:

☐ High Flow Liter Flow:

*High Flow therapy is only accessible when SIMV-Pressure, SIMV-Volume mode or Vol. Targeted SIMV is selected.

☐ Custom Prescription

Hours of Use: ☐ Nocturnal ☐ Daytime ☐ Continuous

Interface: ☐ Mask ☐ Other:

Mode:

Settings:

Additional Ventilation Prescriptions/Supplies:

☐ Heated Humidifier with all required supplies ☐ Heat-Moisture Exchanger (HME)

☐ Circuit ☐ Bacteria Filters ☐ Air and Fan Filters

☐ Patient is wheelchair dependent and requires a second ventilator (one mounted to wheelchair for daytime mobility, and one bedside for nocturnal use). Provide detail:

Prescribing Physician

Name:		Signature:
NPI:	Phone:	Date: