



TRACHEOSTOMY PRESCRIPTION FORM

Patient Name: _____ DOB: _____
Start Date: _____ Refills: (X) Lifetime () Other _____ /Months

Patient's medical record should contain patient has an open surgical tracheostomy; and Tracheostomy has been or is expected to remain open for at least three months. For more information refer to Medicare LCD (L33832)

ICD10 Code must be listed in patient's medical record i.e. Z93.0 or similar (please attach copy of medical record with this prescription)

ICD10 Codes Description

Equipment / Services

A4624 Suction Catheter Kits _____ Fr. (size) (90 per Month)

A7520 / A7521 Tracheostomy Tube (1 per 3 months) Item# _____
Cuffed Cuffless
Fenestrated non-Fenestrated

A4623 Disposable Inner Cannulas (62 per Month) Item# _____

A4629/A4625 Trach Care Kits (31 per Month)

A4216 Saline 3cc (100 units per Month)

A7526 Trach Collar/Ties (31 per Month)

Sterile water/saline solution is only covered when used in conjunction with a suction pump (E0600)

Other: _____

PHYSICIAN ATTESTATION:

I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness.** The patient and/or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicaid or other Insurance for post payment review or audits.

PHYSICIAN NAME: _____ NPI # _____ PHONE # _____

PHYSICIAN SIGNATURE _____

Instructions for Referral Submission

Fax or email completed form along with the documents listed below

- Patient Face Sheet (containing current demographics and insurance)
- Medical Record (must include Diagnosis codes) with in last 30 days that confirms need for supplies based on condition

PH# 877-748-1977

FAX# 866-634-8166

EMAIL: Intake@acsmedical.com

Last update 02/05/2024