Atos

PRESCRIPTION FORM
For Laryngectomy Supplies and/or Communication Equipment

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PATIENT INFO

PATIENT FIRST NAME*	PATIENT LAST NAME*	PATIENT TELEPHONE	PATIENT EMAIL	☐ MALE ☐ FEMALE

STREET*	CITY*	ST*	ZIP*	DATE OF BIRTH (MM/DD/YYYY)*

IMPORTANT: TO ASSIGN AN AUTHORIZED REPRESENTATIVE TO COMMUNICATE WITH ATOS ON YOUR BEHALF, COMPLETE HERE

CAREGIVER FIRST/LAST NAME	CAREGIVER TELEPHONE	CAREGIVER EMAIL

PRESCRIPTION INFORMATION

SPEAKING (VOICE REHABILITATION)

RX	PROVOX VOICE PROSTHESIS	SIZE	LENGTH	QTY	OTHER
RX	☐ Provox Vega [L8509]:	☐ 17Fr ☐ 20Fr ☐ 22.5Fr	☐ 4mm ☐ 6mm ☐ 8mm ☐ 10mm ☐ 12.5mm ☐ 15mm	1/month	
RX	☐ Provox Vega XtraSeal [L8509]:	☐ 17Fr ☐ 20Fr ☐ 22.5Fr	☐ 4mm ☐ 6mm ☐ 8mm ☐ 10mm ☐ 12.5mm ☐ 15mm	1/month	
RX	☐ Provox2 [L8509]:	22.5Fr	☐ 4.5mm ☐ 6mm ☐ 8mm ☐ 10mm ☐ 12.5mm ☐ 15mm	1/month	
RX	☐ Provox ActiValve [L8509]:	22.5Fr: ☐ Light ☐ Strg ☐ XStrg	☐ 4.5mm ☐ 6mm ☐ 8mm ☐ 10mm ☐ 12.5mm	1/month	
RX	☐ Provox NiD [L8507]:	☐ 17Fr ☐ 20Fr	☐ 6mm ☐ 8mm ☐ 10mm ☐ 12mm ☐ 14mm ☐ 18mm	1/month	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
	☐ Voice Prosthesis Brush OR Flush [L8513]	2/month	
	☐ Voice Prosthesis Plug [L8511]	1/month	
	☐ ActiValve Lubricant [A4402]	4oz/month	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
RX	☐ Capsule [L8512]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	15/month	
RX	☐ XtraFlange [L8499]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	1/month	
RX	☐ NiD Dilator [L8514]: ☐ 17Fr ☐ 20Fr	1/month	

RX	PROVOX SPEECH AIDS	QTY	OTHER
	☐ Electrolarynx [L8500]	1	

RX	PROVOX SPEECH AIDS ACCESSORIES	QTY	OTHER
	☐ Electrolarynx Battery [L8505]	1	

BREATHING (PULMONARY REHABILITATION)

RX	PROVOX HMES/ADHESIVES	QTY	OTHER
	☐ Adhesives [A7508]	60/month	
	☐ Heat and Moisture Exchangers-HMEs [A7507]	60/month	
RX	☐ Micron HME [A7507]	60/month	

RX	PROVOX ATTACHMENTS	QTY	OTHER
RX	☐ Provox LaryTube [A7520]: **SIZE** ____/____ **TYPE** ☐ Std ☐ Fen ☐ Rng	1/month	
RX	☐ Provox Life LaryTube [A7520]: **SIZE** ____/____ **TYPE** ☐ Std ☐ Fen ☐ Rng ☐ Fen Rng	1/month	
RX	☐ Provox LaryButton [A7524]: **SIZE** ____/____	1/month	
RX	☐ Provox Life LaryButton [A7524]: **SIZE** ____/____	1/month	
RX	☐ BM Tracheostoma Button [A7524]: **SIZE** ____/____	1/month	

RX	PROVOX HME/ADHESIVE/ATTACH ACCESSORIES	QTY	OTHER
	☐ Cleaning Towel [A4245]	1 box/month	
	☐ Adhesive Remover Wipes [A4456]	50/month	
	☐ Skin Barrier OR Skin Tac Wipes [A5120]	150/month	
	☐ Foam Stoma Cover [A4481]	60/month	
	☐ Double-Sided Foam Disc [A5126]	20/month	
	☐ Silicone Glue [A4364]	4/month	
	☐ Shower Aid [A7523]	1/month	
	☐ BasePlate Adaptor [E1399]	1/month	
	☐ TubeBrush [A4626]	2/month	
RX	☐ Kapi-Gel [L8499]: **ID mm** ☐ 8 ☐ 12 / **TH mm** ☐ 3 ☐ 5	10/month	
	☐ HME Cassette Adaptor (Provox Only) [A7503]	1/6months	
	☐ LaryClip/TubeHolder/Neckband [A7526]	31/month	

HANDS-FREE

RX	PROVOX FREEHANDS FLEXIVOICE/ACCESSORIES	QTY	OTHER
RX	☐ Membrane [A7501]: ☐ Light ☐ Med ☐ Strg ☐ XStrg	1/month	
RX	☐ FreeHands HME [A7507]: ☐ Moist ☐ Flow ☐ Provox Life	60/month	
RX	☐ HME DigiTop (Provox Life Only) [A7503]	1/6months	

RX	PROVOX FREEHANDS ACCESSORIES	QTY	OTHER
RX	☐ HME Cap (Provox Only) [A7503]	1/6months	
	☐ Support Starter Set [E1399]	1/month	
	☐ Support/Adhesive [E1399]	1/month	

TREATING PRACTITIONER/CLINICIAN USE ONLY

ICD-10 CODE REQUIRED (Z43.0 OR Z93.0 FOR MEDICARE)

DIAGNOSIS CODE* (CHOOSE ONE): ☐ Z43.0 Encounter for Attention to Tracheostomy ☐ Z93.0 Tracheostomy Status ☐ _____

CLINICIAN NAME	CLINICIAN TELEPHONE	**COMING HOME KIT REQUESTED** ☐ PROVOX ☐ PROVOX LIFE	DATE OF SURGERY (MM/DD/YYYY)
CLINICIAN EMAIL	CLINICIAN FAX	TO BE SHIPPED TO ABOVE PATIENT ADDRESS. DATE OF SURGERY AND FACILITY NAME REQUIRED.	ORDER DATE (MM/DD/YYYY)*

FACILITY NAME AND ADDRESS	PRODUCT EXCEPTIONS ONLY	NOTES PLEASE SEND COPIES OF MEDICAL RECORDS WITH ANY RX
	TREATING PRACTITIONER NAME*	TREATING PRACTITIONER SIGNATURE* NO STAMPS ALLOWED

I certify the medical necessity of these items including any accessories for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification or omission of material fact may subject me to civil or criminal liability.

This is a prescription form only and will NOT automatically generate an order for shipment. RX VALID 12 MONTHS FROM ORDER DATE *Required

Print Form and Sign