JONES MEDICAL EQUIPMENT
481-B Elma G. Miles Parkway Hinesville, GA 31313 Phone 912-877-3202 Fax 912-877-3206
NPI 1578900841
210 Grand Central Blvd. Pooler, Ga. 31322 Phone 912-988-3718 Fax 912-988-7064
NPI 1396202495

*****ALL PHYSICIANS SCRIPTING FOR MEDICARE AND MEDICAID MUST BE PECOS CERTIFIED AND ENROLLED WITH GAMMIS. INFORMATION WILL BE VERIFIED DURING THE INTAKE PROCESS AND DENIED, IF YOU'RE NOT ENROLLED*****

Suction Machine and Supplies

Patient Name _____ DOB _____

Insurance _____ MBI # _____

Order Date _____ End Date _____

Treating Provider _____ NPI _____

Phone # _____ Fax # _____

Equipment Ordered (Circle All that Apply)- CMS-10126 required for Medicare

E0600- Respiratory Suction Pump, Home Model	QTY _____	
E2000- Gastric Suction Pump, Home Model	QTY _____	
A4216- Sterile Water or Saline, 10ML	QTY _____	Weekly, Monthly, Yearly
A4605- Tracheal Suction Catheter **Size _____**	QTY _____	Weekly, Monthly, Yearly
A4624- Tracheal Suction Catheter, other than closed **Size _____**	QTY _____	Weekly, Monthly, Yearly
A4628- Oropharyngeal suction catheter **Size _____**	QTY _____	Weekly, Monthly, Yearly
A7000- Canister, disposable	QTY _____	Weekly, Monthly, Yearly
A7002- Non Conductive Tubing	QTY _____	Weekly, Monthly, Yearly

To be completed by provider (must be signed by the ordering M.D.)

*****INSTRUCTIONS FOR USE. HOW OFTEN TO SUCTION? HOW MAY TIMES PER DAY*****

_____

Prognosis (circle) Fair Good Poor Length of Need _____ (99= lifetime)

Date of Order (RX) _____ Date of Office Visit _____

DX _____ ICD-10 Code _____

Indication

Does the patient have issues raising and clearing secretions secondary to:

a) Cancer or surgery of the throat yes or no
b) Dysfunction of the swallowing muscles yes or no
c) Unconsciousness or obtunded state yes or no

_____ _____

Physician Signature Date