Request for Ventilator Intake Form

Patient Name: _____ **DOB:** _____
(Last) (First) (M)

Patient Cell # _____ **Permission to text:** ☐ Yes ☐ No **Leave message:** ☐ Yes ☐ No

Patient Home # _____ **Permission to leave patient detailed message on this line:** ☐ Yes ☐ No

Email _____

Patient Address: _____
Street City State Zip

Caregiver Name: _____ **Caregiver Phone #** _____

Ordering Physician: _____ **Physician Phone #** _____

☐ I have a prescription ☐ Please contact this physician for a prescription

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone # _____

Primary Insurance

Name of Insurance: _____ **Effective Date:** _____

Policy # _____ **Group #** _____ **Phone #** _____

Policy Holder (Primary Insured): Self ☐ Other : _____ **DOB:** _____

Address: _____

Secondary Insurance

Name of Insurance: _____ **Effective Date:** _____

Policy # _____ **Group #** _____ **Phone #** _____

Policy Holder (Primary Insured): Self ☐ Other : _____ **DOB:** _____

Address: _____

Diagnosis (ICD-10 Code) _____ _____ _____ _____

Ventilator Type: ☐ Trilogy 100 ☐ LTV 1150 ☐ LTV 1200 ☐ Astral ☐ VOCSN ☐ VC

HCPCS Selection: ☐ E0465 ☐ E0466 ☐ E0467 ☐ E0483 (Afflovest) ☐ E0482 (Cough Assist) ☐ Cpap/Bipap

DME Name: _____ **DME Phone Number:** _____

DME Address _____

Respiratory Therapist: _____ **License Number:** _____

Address _____

Submit Completed Intake Form to

MCO@TraceMedical.com