HANDI MEDICAL SUPPLY

Medical Record Request: AffloVest

Regarding the patient:

Name ______________________ Date of Birth ______________________

For insurance consideration of the High Frequency Chest Wall Oscillation devices (HFCWO) you have requested for this patient, they must meet criterion 1, 2, OR 3, AND criteria 4 below. The following must be documented in their medical records:

1. A diagnosis of Cystic Fibrosis (ICD-10: E84.0, E84.9); ***OR***
2. That the beneficiary has a neuromuscular disease diagnosis (ICD-10: Multiple); ***OR***
3. A diagnosis of Bronchiectasis (ICD-10: J47.0, J47.1, J47.9, Q33.4) which has been confirmed by a high resolution, spiral, or standard CT scan (Please include CT scan interpretation with medical records), and which is characterized by:
   a) Daily productive cough for at least 6 continuous months, ***OR***
   b) 3 or more exacerbations within one year requiring antibiotic therapy documented 3 separate occurrences; ***AND***
4. Alternative airway clearance techniques that have been **tried**, and all reasons why they **failed** to clear secretions.
5. If patient is using nebulized therapy in conjunction with HFCWO.

This is a **medical record request**, which must include **relevant ICD-10 diagnosis code(s)** and the **prescriber's signature and date**. Providing this information to a supplier is not a violation of HIPAA privacy rules and does not require a release.

To expedite processing, please fax medical records and this cover page to: 651-644-9770

Fax back: **651-644-0602** **www.handimedical.com**

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