RespirTech
Advancements in Respiratory Health.

PRESCRIPTION FORM

the inCourage™ system

Please include patient demographic/face sheet and
FAX all documents to Customer Care at 651-379-8998

Patient Name ______________________ Date of Birth ____________ Gender ________

Primary Contact ______________________

Address ______________________ City/State/Zip ______________________

Phone ______________________ Alternate Phone(s) ______________________

Primary Insurance Co ______________________ Phone ______________________

Policy Number ______________________

Secondary Insurance Co ______________________ Phone ______________________

Policy Number ______________________

Pulmonary Diagnosis ______________________

Secondary Diagnosis ______________________

HEALTH CARE FACILITY INFORMATION

Name of Health Care Facility ______________________

Address ______________________ City/State/Zip ______________________

Health Care Team Contact Name(s) ______________________

Phone ______________________ FAX ______________________

PRESCRIPTION

℞ *the InCourage™ System High Frequency Chest Compression Device*

Physician Signature ______________________

Physician Name (Please print) ______________________

Physician NPI ______________________ Date ______________

PRESCRIBED THERAPY (Please check appropriate therapy)

☐ **QUICK START PROGRAM** **(Default therapy if no box is checked)**		☐ **CUSTOM** **(Please complete below)**	
Treatments Per Day:	2	Treatments Per Day:	______
Minutes Per Treatment:	30	Minutes Per Treatment:	______
Frequencies:	6Hz - 15Hz	Frequencies:	______
Pressure:	60%	Pressure:	______

***inCourage*™ System Jacket Size (Largest chest circumference)** Inches:______

☐ **30 DAY EVALUATION (See reverse for description)**

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PRESCRIPTION DESCRIPTIONS

STANDARD
The *inCourage*™ Airway Clearance System will ship immediately when arrangements have been made with the patient. Some payers have stated that they will not pay, or will pay less, if we ship prior to their authorization. In this case, we will make the delivery arrangement in accordance with the patient's preference and the payer's regulation.

30-DAY EVALUATION
This program allows the patient and the physician to assess the effectiveness of the treatment for a 30-day period. When we receive an evaluation prescription with a diagnosis of Cystic Fibrosis or Bronchiectasis, we will ship the device once arrangements have been made with the patient and insurance has been verified.* The reimbursement process will begin when the physician and patient have approved the *inCourage*™ Airway Clearance System for long-term use, upon completion of the evaluation. If, at the end of the evaluation period, the treatment is not right for the patient, the *inCourage*™ Airway Clearance System may be returned without any cost obligation.

*Some insurance programs may require prior authorization before dispensing the device. Diagnoses other than Cystic Fibrosis and Bronchiectasis will be reviewed individually to determine if a prior authorization is required prior to shipping the device.

If you have any questions regarding ordering the *inCourage*™ Airway Clearance System, please call our Customer Care Department at: **1-800-793-1261**

Please fax the front of this form to:

651-379-8998