

**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

R_x *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)
 Treatments Per Day: 2
 Minutes Per Treatment: 30
 Frequencies: 6Hz - 15Hz
 Pressure: 60%

CUSTOM
 (Please complete below)
 Treatments Per Day: _____
 Minutes Per Treatment: _____
 Frequencies: _____
 Pressure: _____

***InCourage*™ System Jacket Size (Largest chest circumference) Inches: _____**

30 DAY EVALUATION (See reverse for description)

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Disclaimer: Affiliate - Cystic Fibrosis Pharmacy, Inc. • 3901 East Colonial Drive • Suite D • Orlando, FL 32803 • Main 407-898-4427 • Fax 407-898-2903, will be used with select insurance programs.

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**