Atos

PRESCRIPTION FORM
TrachPhone

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PATIENT INFO

PATIENT FIRST NAME*	PATIENT LAST NAME*	PATIENT TELEPHONE	PATIENT EMAIL	☐ MALE ☐ FEMALE

STREET*	CITY*	ST*	ZIP*	DATE OF BIRTH (MM/DD/YYYY)*

IMPORTANT: TO ASSIGN AN AUTHORIZED REPRESENTATIVE TO COMMUNICATE WITH ATOS ON YOUR BEHALF, COMPLETE HERE

CAREGIVER FIRST/LAST NAME	CAREGIVER TELEPHONE	CAREGIVER EMAIL

TREATING PRACTITIONER/CLINICIAN USE ONLY

PRESCRIPTION INFO

RX TRACHPHONE	QTY	OTHER
☐ TrachPhone [A7507]	60/month	

ICD-10 CODE REQUIRED (Z43.0 OR Z93.0 FOR MEDICARE)

DIAGNOSIS CODE* (CHOOSE ONE): ☐ Z93.0 Tracheostomy Status

☐ _____ ☐ Z43.0 Encounter for Attention to Tracheostomy

CLINICIAN NAME	CLINICIAN TELEPHONE	DATE OF SURGERY (MM/DD/YYYY)
CLINICIAN EMAIL	CLINICIAN FAX	ORDER DATE (MM/DD/YYYY)*

FACILITY NAME AND ADDRESS	NOTES PLEASE SEND COPIES OF MEDICAL RECORDS WITH ANY RX

TREATING PRACTITIONER NAME*	TREATING PRACTITIONER SIGNATURE* NO STAMPS ALLOWED	SIGNATURE DATE (MM/DD/YYYY)*

I certify the medical necessity of these items including any accessories for this patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employee(s) and reviewed by me. The foregoing information is true, accurate and complete and any falsification or omission of material fact may subject me to civil or criminal liability.

This is a prescription form only and will NOT automatically generate an order for shipment. **RX VALID 12 MONTHS FROM ORDER DATE** ***Required**

Print Form and Sign

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