Application for Chest Wall Oscillator (Vest)

Washington State Health Care Authority

This is confidential information intended only for the person to whom it is faxed. HCA requires all fields to be completed so we can appropriately evaluate the request.

Return this form by **online direct data entry** or fax this form along with the **general information for authorization (GIA) form (13-835)** to Authorization Services at 1-866-668-1214. The GIA form must be typed and must be page 1 of your fax (no fax coversheet).

1 General information

Client name | Date of birth | ProviderOne Client ID

Name of prescribing physician | Telephone number | Provider NPI

Respiratory diagnosis requiring treatment

ICD 9 Dx | Description

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Medical information (to be supplied by prescriber's office or independent respiratory therapist)

1. Is the client currently receiving CPT therapy? ☐ Yes ☐ No

2. Who performs the CPT? Can family members do CPT for the client? Do they need training? Does the client have private duty nursing to do CPT for the client? If CPT is no longer being performed, state reason CPT was discontinued.

3. Is the client able to use the "flutter", "pep", Acapella, or In-exsufflator? If not, why not? For how long have they tried to learn to use these techniques?

4. Describe why all alternate methods of pulmonary toilet have failed including extenuating circumstances that have contributed to their failure:

5. For clients who are **currently using** the vest, provide the following information:

   Date the chest oscillator was started at home _____

   Settings of oscillator _____

   Number of times the chest oscillator is used each day _____

Daily prescription including frequency, dose, and duration

Daily prescription	Frequency	Dose	Duration
Daily prescription	Frequency	Dose	Duration
Daily prescription	Frequency	Dose	Duration
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Number of hospitalizations for the 12 months before vest _____

Number of hospitalizations for the 12 months after vest **or since beginning vest usage** _____

Total office visits for 12 months before vest _____

Total office visits **since starting vest** _____

Total ER visits for 12 months before vest _____

Total ER visits **since starting vest** _____

Total episodes of antibiotic treatment before vest _____

Total episodes of antibiotic treatment since starting vest _____

Best pulmonary function tests within 12 months before and after vest (attach).

If the client has a vest but is **not currently using** the vest please describe the reason the vest is not being used:

Name of person completing this form	Position	Billing provider NPI
Telephone number	Fax number	