

This form serves as a certificate of medical necessity and prescription for the Rocket Medical PC Drainage Pack and supplies that may be provided by either Rocket Medical or another provider to be determined at Rocket Medical's discretion. To ensure timely, efficient processing of your patient's order, all information requested on **this form MUST BE FILLED OUT COMPLETELY, all fields are required, or SHIPMENT OF SUPPLIES WILL BE DELAYED.**

PATIENT CONTACT INFORMATION			
Name (Last, First):			D.O.B.:
Street Address:			City:
State:	Zip:	Phone #:	Phone 2 #:
EMERGENCY CONTACT NAME:			PHONE #:

PATIENT INSURANCE INFORMATION		
Primary Insurance Name:		Phone #:
Insurance ID#:	Group Name:	Group #:
Secondary Insurance Name:		Phone #:
Insurance ID#:	Group Name:	Group #:

Date of Insertion → ___/___/___ Date of Discharge → ___/___/___ # of Bottles Patient is Being Discharged with → ___

Patient is being discharged to → **PLEASE CHECK ONE**

Home with no nurse in home
 Nurse in home (HHA/VNA) → please complete Care Agency details below
 Skilled Nursing Facility (SNF) → please complete Care Agency details below
 Hospice → please complete Care Agency details below

Care Start Date / Care Agency Name / Care Agency Contact Person / Care Agency Contact Phone #

PHYSICIAN'S ORDER FOR ROCKET MEDICAL IPC	
Physician Name:	NPI #:
Hospital/Clinic Name:	Phone #:
ROCKET IPC POC AT PHYSICIAN'S OFFICE:	Fax #:

Patient's **Primary ICD10 Diagnosis Required** (Please Appropriate Diagnosis) - **Location of Fluid Accumulation**

J91.0 Malignant Pleural Effusion
 J91.8 Unspecified Pleural Effusion Other ASCITES R18.8: _____

Patient's **Secondary ICD10 Diagnosis Required** (Please Provide Appropriate Diagnosis) - **Condition Causing Drainage**

Treatment →: _____ (For Example: C34.90 Lung Cancer, C50.919 Breast Cancer, C56.9 Ovarian Cancer, 150.XX CHF)

Replace and drain per the following (Check one):

Once per day = 90 Rocket IPC Drainage Packs & Bottle Kits / 90 days
 Every other day = 45 Rocket IPC Drainage Packs & Bottle Kits / 90 days
 Other = _____ # of Rocket IPC Drainage Packs & Bottle Kits / 90 days

Duration of Need in Months →: _____ 1-99
(99 = Lifetime)

Refills: PRN

Each R51400 Rocket IPC Drainage Pack & Bottle Kit contains a pre-evacuated bottle with patient control flow valve, new valve cap, split foam dressing, non-latex gloves, gauze swabs, alcohol wipes, c-view dressing, blue slide clamp & waste bag.

Physician Attestation: I certify that I am the Physician identified on this form. I have reviewed this Certificate of Medical Necessity. Any statement on my Letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's medical record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and will be provided to Advanced Cardio Services upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Signature: _____

SIGNATURE STAMPS ARE NOT ACCEPTABLE

Date: _____

DATE STAMPS ARE NOT ACCEPTABLE

★★★★PLEASE SEND COMPLETED FORM & LAST TWO CHART NOTES TO★★★★

E-Mail: USA@RocketMedical.com FAX #: (781) 735-5515 or CALL TOLL FREE: (800) 707-ROCKET (7625)