Rocketmedical

DRAINAGE KIT **PHYSICIAN ORDER / CERTIFICATE OF MEDICAL NECESSITY**

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
- ☐ R18.0 Malignant ascites: _____
- ☐ 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, I50.XX CHF)

☐ 1L Bottle ☐ 600ML Bottle ☐ 2L Bag

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 case contains 5 Rocket IPC Drainage Packs & Bottle Kits. Kits contain 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.

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 Rocket Medical PLC 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: _____ **Date:** _____

SIGNATURE STAMPS ARE NOT ACCEPTABLE **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)**