

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 #:
<b>EMERGENCY CONTACT NAME:</b>			<b>PHONE #:</b>

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 #:
<b>ROCKET IPC POC AT PHYSICIAN'S OFFICE:</b>	Fax #:

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

J91.0 Malignant Pleural Effusion       R18.0 Malignant ascites: \_\_\_\_\_  
 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)

**Drain per the following** ( Check one):

**Check drainage preference**

1 Liter Bottle     600ml Bottle     2 Liter Bag

**Duration of Need in Months** →: \_\_\_\_ 1-99

Once per day = 90 Rocket IPC Drainage Kits / 90 days

**(99 = Lifetime)**

Every other day = 45 Rocket IPC Drainage Kits / 90 days

Other = \_\_\_\_\_ # of Rocket IPC Drainage Kits / 90 days

**Refills:** PRN

**Rocket IPC Drainage Kits contain a pre-evacuated bottle/bag 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](mailto:USA@RocketMedical.com)    FAX #: (781) 735-5515    or    CALL TOLL FREE: (800) 707-ROCKET (7625)