



Prescription and Diagnosis Form

Not an Order – Prescription Form Only. Please contact Customer Support to confirm & place an order of the below items.

Patient Info

Patient Name		Phone #	
Street Address		Email	
City	State	Zip Code	Date of Birth (YYYY-MM-DD)
Insurance Carrier	Insurance Phone	Policy #	
		Female Male	

Prescription Information

QTY/MO	Description	REF	QTY	QTY/MO	Description	REF	QTY
HMEs & Hands free housings				Stoma Cover (patches)			
	LARYVOX® O2 HME	49802	30		LARYTAPE® S	45960	10
	LARYVOX® HME	49800	30		LARYTAPE® L	45962	10
	LARYVOX® HME HighFlow	49810	30		LARYTAPE® TOUCH S	45970	10
	LARYVOX® Hands-Free Valve Kombi HME Low Resistance	21982	1		LARYTAPE® TOUCH L	45972	10
	LARYVOX® Hands-Free Valve Kombi HME Normal Resistance	21983	1		LARYNGOFIX®, Small, Beige	45900	10
HME & Hands Free Sets					LARYNGOFIX®, Large, Beige	45950	10
	LARYVOX® Hands-Free Set	21986	1 set		LARYNGOFIX®, Small, White	45905	10
	LARYVOX® Starter Set	48810	1 set		LARYNGOFIX®, Large, White	45955	10
New HMEs (TOUCH)					LARYNGOFIX® PRO S, Beige	45901	10
	LARYVOX® TOUCH HME HighFlow		30		LARYNGOFIX® PRO L, Beige	45956	10
	LARYVOX® TOUCH Starter Set	48820	1 set		LARYNGOFIX® PLUS, Small, Beige	45902	10
New HMEs (STYLE)					LARYNGOFIX® PLUS L, Beige	45952	10
	LARYVOX® STYLE HME High-Flow (only filter cassettes)	49880	30	Cleaning and Care			
	LARYVOX® STYLE HME (only filter cassettes)	49881	30		OPTIFAHL® Stoma Cleaning Wipes, Individual	33200	30
	LARYVOX® STYLE HME High-Flow SET	49880-90	1 set		OPTIFAHL® Stoma Cleaning Wipes, Container	33260	60
	LARYVOX® STYLE SET	49881-90	1 set		OPTICLEAR® adhesive remover	33500	30
	LARYVOX® STYLE TOP lamella SET	49830-90	1 set		OPTIGARD® skin protection film	33600	30
	LARYVOX® STYLE CAP round SET	49820-90	1 set		LARYVOX® DUO BRUSH		6
	LARYVOX® STYLE TOP lamella		3		OPTIBRUSH® Set	31011	1 set
	LARYVOX® STYLE CAP round		3		OPTIBRUSH® CLEAN	31110	3.5 oz
LARYVOX® Adhesive Base plates					OPTIBRUSH® Container	31200	1
	Comfort		15		OPTIBRUSH®		4
	Standard		15		OPTIBRUSH® PLUS		4
	Flexible		15		OPTIBRUSH® BASIC		4
	Hydrosoft		15		OPTIBRUSH® SWAB	31910	30
	Extra Fine Rectangular	48400	15		OPTIBRUSH® SWAB XL	31920	30
LARYNGOTEC® Silicone Tubes					LARYVOX® Tweezers	35000	1
	LARYNGOTEC® Kombi		1	Emergency Sets & Accessories			
	LARYNGOTEC® Lingo Kombi		1		SECUTRACH® Shower Guard	47000	1
	LARYNGOTEC® Lingo Kombi Cut		1		LARYVOX® SECUTRACH® Shower Guard	47400	1
	LARYNGOTEC® Lingo Kombi Clip		1		LARYVOX® Connect	48915	1
	LARYNGOTEC® Kombi Clip		1		LARYVOX® Adapt	48920	1
SINGER Tube					LARYVOX® Distance Holder	34000	1
	SINGER Laryngectomy Tubes		1		LARYVOX® SOS Safe-Mask	75000	1
LARYNGOTEC® Buttons					LARYVOX® SOS Mask	75010	1
	LARYNGOTEC® Kombi Stoma Button FIX - Standard		1		LARYVOX® Smell	75130	1
	LARYNGOTEC® Kombi Stoma Button FIX - Short		1		LARYVOX® Mask	75200	1
	LARYNGOTEC® Kombi Stoma Button - Standard		1		LARYVOX® Safety Set	48006	1
	LARYNGOTEC® Kombi Stoma Button - Short		1		LARYVOX® Emergency Set	48007	1
OTHER					LARYVOX® Nebulizer	58000	1
					Tube Holders		
					OPTIFLAUSCH® Tube Holder with adherent fastener	32550	1
					OPTIFLAUSCH® Tube Holder with plastic hook	32551	1
					Electrolarynges		
					SERVOX® Digital EL	SV02	1 kit
					SERVOX® Inton EL	SV01	1 kit
					SERVOX® Battery	SV33	1

Physician/Clinician Use Only

Diagnosis	
Diagnosis (ICD-10)	Date needed (YYYY-MM-DD)
# of months needed (1-99 months, 99=life)	Reason for Medical Necessity
SLP Name	SLP Phone #
I certify the medical necessity of this item for this patient. This section of the form and any statement on my letter head attached here to has been completed by me or by my employees, and reviewed by me. The foregoing information is true, accurate and complete, and any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.	
Facility Name and Address	NPI
	Email
	License #
Physician/Clinician Name	Signature and Date

Please and sign