INHEALTH
TECHNOLOGIES®

Name	Phone	Date of Birth	
Street Address	City	State	Zip
Email		Gender	

PRESCRIPTION AND MEDICAL NECESSITY FORM

Please complete all necessary fields and mail, fax, or email to: IHT Customer Service • 1110 Mark Ave • Carpinteria, CA 93013 • **Fax:** 734-354-5757 • **Email:** ihtrx@inhealth.com • **Customer Service:** 800-477-5969

BLOM-SINGER® VOICE PROSTHESES (1 EA)

PATIENT CHANGEABLE	DIAMETER (Fr)	LENGTH (mm)	QTY/FREQ	OTHER
Duckbill	16 Fr only	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 — ☐ 18	2/mo	
Low Pressure	☐ 16 ☐ 20	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ 20 ☐ 22 ☐ 25 ☐ 28 (16Fr only)	2/mo	
Low Pressure - Special Order Increased Resistance	16 Fr only	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 — ☐ 18 — ☐ 22 ☐ 25 ☐ 28	2/mo	
Low Pressure - Special Order Increased Resistance	20 Fr only	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	2/mo	

CLINICIAN PLACED/INDWELLING	DIAMETER (FR)	LENGTH (mm)	QTY/FREQ	OTHER
Classic – Sterile	☐ 16 ☐ 20	☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	
Classic – Non-Sterile	☐ 16 ☐ 20	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ 20	1/mo	
Advantage® Soft Valve (AS)	☐ 16 ☐ 20	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	
Advantage® Hard Valve (AD)	20 Fr only	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	
Dual Valve™ (DV)	☐ 20 ☐ 20 (LF)	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	

CLINICIAN PLACED/INDWELLING - SPECIAL ORDER:	☐ 16 Fr ☐ 20 Fr	QTY/FREQ	OTHER		QTY/FREQ	OTHER
Special Length (SL)	☐ 5 ☐ 7 ☐ 9	1/mo		Large Esophageal & Tracheal Flanges (LF)	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	
Increased Resistance (IR)	☐ 6 ☐ 8 ☐ 10 ☐ 12	1/mo		Large Esophageal Flange - Increased Resistance (LEIR)	☐ 4 ☐ 6 ☐ 8	1/mo	
Large Esophageal Flange (LEF)	☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo		Large Esophageal Flange - TEP Occluder (LETO)	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14	1/mo	

BLOM-SINGER® VOICE PROSTHESIS ACCESSORIES	QTY/FREQ	OTHER		QTY/FREQ	OTHER
Tracheoesophageal Puncture Dilator (1 EA) ☐ 18 Fr ☐ 22 Fr	1/mo		Plug Insert (1 EA) ☐ 16 Fr ☐ 20 Fr	1/mo	
Replacement Gel Caps (1 pk) ☐ 16 Fr ☐ 18 Fr ☐ 20 Fr ☐ 22 Fr	1/mo		Cleaning Brushes (3 EA) ☐ 4-8 mm ☐ 9-16 mm ☐ 18-22 mm	1/mo	
Flushing Device (3 EA) ☐ (one size fits all)				1/mo	

BLOM-SINGER® HME (30 EA unless otherwise noted)
☐ Check here to include all HMEs or specify below

	QTY/FREQ	OTHER		QTY/FREQ	OTHER
☐ SpeakFree® HME with Hands Free Valve: ClassicFlow®	2 bx/mo		☐ SpeakFree® HME with Hands Free Valve: EasyFlow®	2 bx/mo	
☐ Day&Night® HME Heat & Moisture Exchange: ClassicFlow®	2 bx/mo		☐ Day&Night® HME Heat & Moisture Exchange: EasyFlow®	2 bx/mo	

BLOM-SINGER® ADHESIVE HOUSING (30 EA unless otherwise noted)
☐ Check here to include all HOUSINGS or specify below

	QTY/FREQ	OTHER
☐ AccuFit® Adhesive Housing	2 bx/mo	
☐ HydroFit® Adhesive Housing	2 bx/mo	

LARYNGECTOMY TUBES & ACCESSORIES (1 EA unless otherwise noted)		QTY/FREQ	OTHER
☐ StomaSoft® HME-Compatible Tube (Non-Fenestrated)	☐ Fenestrated ☐ 8/36 ☐ 8/55 ☐ 9/36 ☐ 9/55 ☐ 10/36 ☐ 10/55 ☐ 12/36 ☐ 12/55	1/3 mo	
☐ Blom-Singer® Sterile/Non-Fenestrated Laryngectomy Tube	☐ 8/36 ☐ 8/55 ☐ 9/36 ☐ 9/55 ☐ 10/36 ☐ 10/55 ☐ 12/36 ☐ 12/55	1/3 mo	
☐ Marpac Tracheostomy Tube Holder 204		15/mo	

ELECTROLARYNX (1 EA)	QTY/FREQ	OTHER
☐ Blom-Singer® ElectroLarynx EL1000	1/5 yr	

BLOM-SINGER® TRACHEOSTOMA ACCESSORIES & SKIN CARE	QTY/FREQ	OTHER		QTY/FREQ	OTHER
☐ Shower Guard (housing and tape discs included) (1 kit)	1/mo		☐ Skin-Prep™ Barrier Wipes, box of 50	3/mo	
☐ Tracheostoma Valve Housing (1 ea) ☐ Standard ☐ Large	2/3 mo		☐ Skin-Tac™ Wipes, box of 50 (1 bx)	3/mo	
☐ Adhesive Tape Discs (30 pk) ☐ Standard ☐ Large	2/mo		☐ Remove™ Adhesive Remover Wipes, box of 50 (1 bx)	1/mo	
☐ ADDvox® Stoma Filters w/Microporous Adhesive (60 pk)	1/mo		☐ Silicone Adhesive Glue (1 oz)	2/mo	
☐ Foam Stoma Protector (30 pk)	2/mo		☐ **Other:**	1/mo	

DIAGNOSIS AND PHYSICIAN INFORMATION (*Required)

Diagnosis ICD-10: **Z43.0, R49.1, R09.3, C32.9** Other: | Rx Start Date (if different than date below)

Reason for Medical Necessity: **Laryngectomy** Other: **PLEASE SUBMIT MEDICAL RECORDS WITH Rx**

☐ I hereby authorize InHealth Technologies to ship prescribed Indwelling Voice Prosthesis directly to patient

Facility Name Address City/State/Zip	SLP Name SLP Email	SLP Phone Fax
***Physician Name**	Physician Email (optional)	Phone
***Physician Signature** (no stamps allowed)	***Signature Date**	***NPI #**

I certify the medical necessity of this item for the patient. This section of the form and any statement on my letterhead attached here has been completed by me or by my employees and reviewed by me. The foregoing information is true, accurate and complete; any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Caution: Federal (USA) law restricts these devices to sale by or on the order of a physician. The products list, physician notes, and other supporting documentation will be provided to InHealth Technologies and/or an authorized distributor upon request.

This is a prescription form only and will NOT automatically generate an order. Rx valid for 1 year from signature date unless otherwise indicated.
WE DO NOT SUBSTITUTE PRODUCT.