LETTER OF MEDICAL NECESSITY FOR VIBRALUNG® ACOUSTICAL PERCUSSOR
Re:

Patient Name: _____ DOB:_____

Address: _____City/State: _____Zip:_____

Diagnosis: _____Diagnosis Code: _____

Secondary DX: _____Secondary DX Code: _____

To whom it May Concern:

The above named patient is under my care for the diagnoses shown above. This patient's diagnoses are a severe, degenerative disease that is non-curative. It does cause severe morbidity resulting in frequent healthcare visits and hospital admissions. Comprehensive airway clearance is one of the most effective ways to reduce the severity of their disease and improve their overall health.

This airway clearance is medically necessary, and cannot be substituted. My patient will benefit from the Vibralung technology since the system systematically clears large to small airways, enabling them to cough up more secretions with less effort. I strongly recommend approval of the Vibralung Acoustical Percussor therapy to improve their ability to adhere to daily needs of airway clearance. It is a safe, gentle, and highly effective therapy to treat the entire pulmonary system.

The Vibralung applies oscillatory vibrational sound waves directly to the respiratory system for greater efficacy in airway clearance. The tonal settings (L-Low, M-Medium, and H-High) vibrate, thin, and thus mobilize mucus. The random noise settings (R2 and R5) relax and open the airways. As the airways are cleared the patient should experience more productive cough, easier breathing, improved lung function, and increased blood gas perfusion, thus improving oxygenation. The Vibralung also provides variable Positive Expiratory Pressure (PEP).

A University of Arizona study compared Vibralung with vest therapy on inpatients with cystic fibrosis and concluded that the device was essentially comparable to the vest with respect to sputum clearance.

(Additional information for this patient such as condition, medical history, complication, exacerbations, hospitalizations, treatment history and prognosis.)

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Due to the progressive and chronic nature of this patient's disease, they will need the Vibralung therapy long term to life. I appreciate your consideration in obtaining this therapy for our mutual patient.

Sincerely,

Physician Signature:_____

Physician Name (Print): _____

Physician NPI #: _____ Phone:_____

Address: _____City/State: _____Zip:_____

Date: _____ Clinic Name:_____

