QUESTIONNAIRE #14
MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Colorado Medicaid ID #:</th>
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The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

1) What is the complete diagnosis with complicating factors:

2) Has client received The Vest ™ treatment in the past?
   a) If yes, how recently was treatment given (in months)?
   b) For how long?
   c) If treatments were discontinued, why?

   □ Yes  □ No
   □ Current  □ 1-6 months ago  □ More than 6 months ago
   Length of Time: 

3) Hospitalization history (in the past year prior to The Vest ™ treatment for clients currently using system):

   Admit Date:               Diagnosis: 
   Admit Date:               Diagnosis: 

   □ Check if additional information is included.

4) Manual percussion therapy (in past 6 months)

   Times per day prescribed/required:  Length of time:
   Primary Caregiver:  Results/Comments:

5) Flutter therapy (in past 6 months)

   Times per day prescribed/required:  Length of time:
   Primary Caregiver:  Results/Comments:

6) Other mechanical therapy (in past 6 months)

   Times per day prescribed/required:  Length of time:
   Primary Caregiver:  Results/Comments:

7) Please supply any additional information that will assist us in determining medical necessity for your request:

Print Prescriber Name: ____________________________________________
Prescriber Signature: ____________________________________________ Date: __________________

Revision Date: 09/15

Page 1 of 1