Virginia Head and Neck Therapeutics, Inc.
10149 Bon Air Crest Dr. Richmond, VA, 23235
804.803.1840 | www.voutia.com

voutia™

CERTIFICATE OF **MEDICAL NECESSITY (CMN)**

Healthcare Professional Name: _____

NPI:_____ Phone :_____ Fax:_____

Address:_____City: _____ State: ____ Zip:_____

Email:_____ Office Contact:_____

Other Requesting Provider:_____

SLP Other: _____

Phone:_____ Email:_____

Patient Name: _____

DOB:_____ Phone:_____

Address:_____City: _____ State: ____ Zip:_____

Cell/Work Phone:_____

Alt. Contact:_____ Alt. Contact Phone: _____

Notes: Medical necessity for the Voutia™ System:

Oral supplementation/Oral hydration system. (DME Code: E1399)

Duration of use/need: _____ Or 99 months/Indefinite (if blank)

Reasons for Medical Necessity:

_____

_____

_____

_____

_____

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_____

_____

Diagnosis Codes:

ICD 10 Code K11.7: Disturbances of salivary secretion

ICD 10 Code M35.00: Sicca syndrome, unspecified (Sjogren's Disease)

ICD 10 Code M35.09: Sicca syndrome (Sjogren's Disease) with other organ involvement

ICD 10 Code R68.2: Dry mouth, unspecified

Primary Diagnosis Code: _____

Other:_____

(Please use ICD-10 codes. List cancer or trauma first.)

Needed by or Surgery Date (if applicable):

_____

☐ I certify the patient does not have an impaired swallow or gag reflex, pulmonary disease, is not at an aspiration risk, has not had a history of or is susceptible to recurrent pneumonia, has not failed a physician prescribed swallow test and has the cognitive ability to operate the system. I understand the usage and function of the device, and the prescribed equipment are reasonable and necessary to treat the patient. I certify the medical necessity of this item for the above patient. This form has been accurately completed by my office and I have reviewed it.

Healthcare Professional Signature: _____ **Date:** _____