


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEBULIZER AND OXIMETER**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	Patient Name, Address, Telephone & HIC#: () - HIC#: _____ Patient DOB: / / Sex: (M/F)
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We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

NEBULIZER AND SUPPLIES:

Date of Service: _____
Diagnosis and Code: _____
Length of Need (# of months) _____ 1-99 (99=life)
Patient Height: _____ ft. in. Weight: _____ lbs.
 Aerosol (Nebulizer) Machine (E0570)
 Nebulizer Cup, Disposable (A7003) – 2 per 1 month
 Nebulizer Cup, Reusable (A7005) – 1 per 6 months
 Mask, Adult (Nebulizer) (A7015) – 1 per 1 month
 Mask, Pediatric (Nebulizer) (A7015) – 1 per 1 month
 Mask, Trache (Nebulizer) (A7525) – 1 per 1 month
Medication: _____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA
A small volume nebulizer is necessary to administer the following types of medication:

- Beta-adrenergics, corticosteroids, or cromolyn for management of obstructive pulmonary disease.
- Gentamicin, tobramycin, amikacin, or dornase alpha for management of cystic fibrosis.
- Pentamidine for patients with HIV.
- Mucolytics (other than dornase alpha) for persistently thick or tenacious secretions.
- Cortizosteriods or other anti-inflammatory medication for the long term treatment and management of asthma.

Has a metered dose inhaler (MDI) with and without a reservoir or spacer device been used or considered, and found not sufficient for the administration of the needed inhalation drug?
 Y N

OXIMETER:

Date of Service: _____
Diagnosis and Code: _____
Length of Need (# of months) _____ 1-99 (99=life)
Patient Height: _____ ft. in. Weight: _____ lbs.
 Continuous (E0445)
_____ # hr/day
Alarm Settings:
Saturation (PO2): High _____ Low _____
Pulse: High _____ Low _____
 Probes, Disposable (A4606) – 20 per 1 month
 Non-Continuous / Spot Checking (E0445)
_____ # times/day

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA
Does the patient have a condition that requires monitoring of the oxygen saturation level?
 Y N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature Date

Provider's Name
NPI: _____ Telephone: _____