℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEBULIZER AND OXIMETER

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**(_____) _____ - _____ HIC#:_____.** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. 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. Prepared by:_____

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, 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-inflamatory 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) – 1 /month **>QTY =LMN**

☐ 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: _____