℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEBULIZER AND OXIMETER

Date of Last Provider Visit_____

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

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:

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, Trach (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:

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: _____