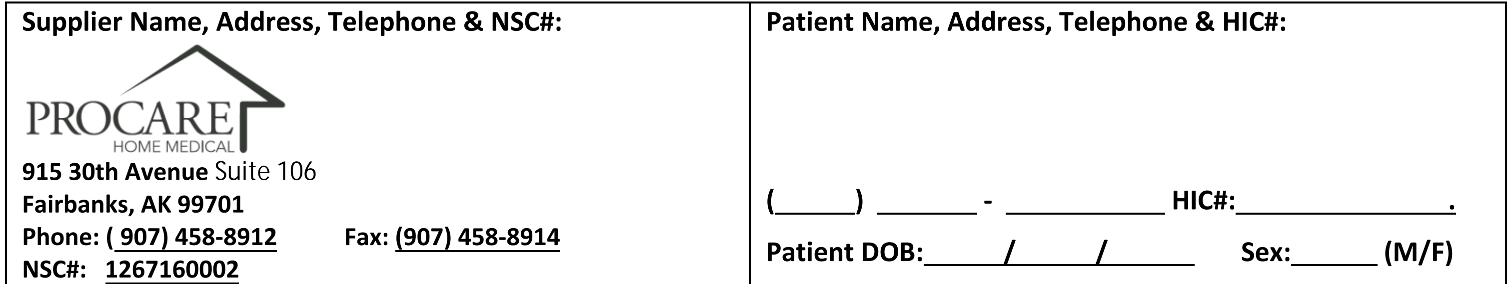
℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEBULIZER AND OXIMETER

Date of Last Provider Visit__________________



Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** Suite 106 **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**(_____) _______ - ___________ HIC#:_______________.** **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:____________________________________

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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: ________________

Updated 07-23-20