


**CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEBULIZER AND OXIMETER**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  3519 Industrial Avenue Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1267160002	Patient Name, Address, Telephone & HIC#: () - HIC#: . Patient DOB: / / Sex: (M/F)
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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-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: _____