NEBULIZER STANDARD WRITTEN ORDER

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<td>Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com</td>
<td>Patient Name, Address, Telephone & Insurance ID #:

Phone:______________________ Ins ID#: ______________
Patient DOB:____________________ Sex: ______(M/F)</td>
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Please fax orders along with required documentation to **(907) 274-0773** or email to **dme@procarehm.com**
Refer to coverage criteria sheet for all required documentation.

NEBULIZER AND SUPPLIES:

Date of Last Visit: _________________________________

Diagnosis and Code: ____

Length of Need (# of months)_______________1-99 (99=life)

Aerosol (Nebulizer) Machine (E0570)

Disposable Filter (A7013) 2/month

Mask Adult (A7015) 1/month

Mask Pediatric (A7015) 1/month

Mask, Trach (Nebulizer) (A7525) 1/month

Reusable Neb Kit (A7005) 1 per 6 months **OR** Disposable Neb kits (A7003) 2/month

Medication: ____

____

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:______________NPI:______________________

Provider's Name: ____ Telephone: _________________________________

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