

**NEBULIZER STANDARD WRITTEN ORDER**

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|  <p>Please fax to:<br/>Anchorage (907) 274-0773<br/>Fairbanks (907) 458-8914<br/>Soldotna (907) 260-3757<br/>Wasilla (907) 357-7883<br/>or email to:<br/>dme@procarehm.com</p> | <p><b>Patient Name, Address, Telephone &amp; Insurance ID #:</b></p> <p>Phone: _____ Ins ID#: _____<br/>Patient DOB: _____ Sex: _____ (M/F)</p> |
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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: \_\_\_\_\_ Order Date: \_\_\_\_\_

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: \_\_\_\_\_