Nebulizer

Physician Order/Prescription

Referred by: Name___________________

Office___________________________

Phone #__________________________

DATE____/____/________

800-540-7252

Fax completed form with Physician's Signature to 888-651-6709

Patient Information

Patient Name: ______________________ Date of Birth: __________ Gender M / F

Patient Phone #: __________ Alternate Contact: __________ Alternate Phone #: __________

Address: __________ City: __________ State: ______ Zip Code: ______

Insurance & ID# __________ Group # __________ Social Security #: __________

Medicaid #: __________ Secondary Insurance: __________

DISCHARGE DATE____/____/________ DELIVERY DATE____/____/________ DELIVER TO: (CIRCLE ONE) HOME OR REFERRAL

Products Dispensed

____Nebulizer Compressor E0570 ___Misty Tee A7003 ___Mask A7003 ___Filters A7013 ___Adult ___Infant ___Pediatric

Diagnosis Information

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME)

DIAGNOSIS CODE/DESC (ICD): ___________________ DIAGNOSIS CODE/DESC (ICD): ___________________

DIAGNOSIS CODE/DESC (ICD): ___________________ DIAGNOSIS CODE/DESC (ICD): ___________________

IF MEDICARE PLEASE FAX MEDICATION RX FOR OUR RECORDS

DATE LAST SEEN BY PHYSICIAN ___/___/______

Medical Justification ____

PLEASE SEND CLINICAL NOTES

Physician Information

Physician's Name: __________ Phone #: __________ Fax #: __________

Address: __________ City: __________ State: ______ Zip: ______

UPIN #: __________ NPI #: __________ License #: __________ Exp Date: ______/______/______ (MM DD YY)

Physician's Signature ______________________________ **Date** ______/______/______ (MM DD YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Approved By