ADVANCED MEDICAL SOLUTIONS

800-248-2229 OPTION 1 FAX TO: 800-552-9443

Nebulizer - Detailed Written Order Prior to Delivery

Reset Form

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

☐ Face Sheet/Demographics/Chart Notes Attached

- Chart notes must include the need for equipment being ordered and **MUST BE ATTACHED FOR OVER QUANTITY**

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order**: _____

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:
Reason for Medical Necessity (other than diagnosis): _____

DIAGNOSIS (check applicable diagnosis below) **Length of Need:** ☐ 12 Months ☐ Other _____ 99 = Lifetime

☐	Asthma	☐	Cystic Fibrosis w/Pulmonary Manifestations
☐	Bronchitis	☐	Pneumonia
☐	COPD	☐	Other _____

NEBULIZER PRODUCTS

☐	Nebulizer w/ Compressor (E0570)
☐	Other _____

ACCESSORIES – The following are medically necessary. (Cross of equipment/supplies not ordered)

☒	Disposable nebulizer set, 2 monthly (A7003)	☒	Reusable nebulizer set, 1 every 6 months (A7005)
☒	Aerosol mask, 1 monthly	☒	Disposable filter, 2 monthly (A7013)
☒	Reusable filter, 1 every 3 months (A7014)	☒	Disposable small volume nebulizer set, 2 monthly (A7004)

NEBULIZER SOLUTIONS/DOSE

☒	Albuterol Sulfate	Frequency _____ X Daily
☐	Other	Frequency _____ X Daily

OVERNIGHT PULSE OXIMETRY TEST ☐

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Signature Date _____

(Stamped Signature Not Accepted)