Nebulizer Detailed Written Order / Delivery Request

Pat:

Clinic:

Rep:

Supplier Address:	Supplier Phone:	Supplier NPI:	Supplier Tax ID:
19015 S Jodi Road, Ste A, Mokena, IL 60448	708-633-1560	1053364695	201668371

Date:

Patient information | Delivery / shipping information and address

First name: _____ MI: _____ Last name: _____

Address: _____ Unit/Apt: ____ City, state, zip: _____

DOB: _____ /_____ /_____ *Mobile phone: (_____) _____

*I, the patient/guarantor, agree to receive text messages from Neb Medical Services. I understand Neb Medical will text me only if additional information is needed to process my nebulizer order. I understand all text messages will stop upon completion of my nebulizer order, or if I text **STOP** to opt out at any time. I may also text **HELP** for assistance. Message and data rates may apply.

*Patient/Guarantor signature:

Guarantor / Signor information / ship to name | Complete this portion only if patient is a minor

First name: _____ M.I._____ Last name: _____ DOB: _____ /_____ /_____

Relation to patient: Mother Father Other _____ **Social Security Number (required):** _____-_____-_____

Insurance information (please attach a copy of insurance card) | Commercial HMO's require pre-authorization

Primary: _____ ID: _____ Group: _____ Referral #: _____

HMO's require referral/pre-auth

Secondary: _____ ID: _____ Group: _____

Clinic information | Please print prescribing physician's name and NPI

Provider first name: _____ **Last:** _____ **NPI:** _____

Clinic name: _____ Phone: _____

Address: _____ Suite: _____

City, state, zip: _____

Certificate of Medical Necessity | All fields to be completed by Provider

Provider signature: stamped signatures not acceptable **Provider credentials:** **Signature date:**

Equipment prescribed	QTY	Frequency of use	Length of need
Nebulizer Compressor **(E0570)**	(1)	1 unit / 5 years	99 months, unless otherwise specified here: _____ months - *Rental permitted for Tricare*
Aerosol Mask **(A7015)**	(1)	1 unit / 30 days	99 months – Purchase only
Reusable Nebulizer Cup **(A7005)**	(2)	2 units / 365 days	99 months – Purchase only

Compressor serial number:

Start date of the order: _____ /_____ /_____ **Brand / Model number:** Philips InnoSpire / 1129539

DX: (circle)	Unspecified asthma, uncomplicated **J45.909**	Acute bronchiolitis, unspecified **J21.9**	Bronchitis, not specified **J40**	Acute bronchitis, unspecified **J20.9**	Chronic bronchitis, unspecified **J41.0**	Acute bronchospasm **J98.01**	RSV as cause of diseases classified elsewhere **B97.4**
Cystic Fibrosis, unspecified **E84.9**	Cough **R05**	Acute bronchitis due to RSV **J20.5**	Acute bronchiolitis due to RSV **J21.0**	Wheezing **R06.2**	***Other:**_____		

Brief narrative of medical necessity / directions for use: **(include name of medication / frequency of treatment – medication is not supplied by NMS, this is a CMS requirement)**

Fax to Neb Medical Services with a copy of insurance card and HMO pre-authorization – main fax (708) 633 – 1574, alternative fax (708) 429 – 5313