



# Reusable Nebulizer Detailed Written Order/Delivery Request

Supplier Address:  
19015 S Jodi Road, Ste A, Mokena, IL 60448

Supplier Phone:  
708-633-1560

Supplier NPI:  
1053364695

Supplier Tax ID:  
201668371

Pat:

Clinic:

Rep:

Date:

## Patient information

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 reusable nebulizer order. I understand all text messages will stop upon completion of my reusable 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 #: \_\_\_\_\_  
Secondary: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_ **HMO's require referral/pre-auth**

## 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	Brand / Model number:	Brand / Model number:
Reusable Nebulizer Cup (A7005)	(1)	2 units / 365 days	99 months – Purchase only	<input type="checkbox"/> Pari LC Sprint / 023F35	<input type="checkbox"/> Philips Sidestream / HS860
Aerosol Mask (A7015)	(1)	1 unit / 30 days	99 months – Purchase only	<input type="checkbox"/> Pari Bubbles the Fish / 044F7248	<input type="checkbox"/> Philips Tucker the Turtle / 1044382

**Start date of the order:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>DX: (circle)</b>	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	<b>*Other:</b> _____		

**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**