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Nebulizer

Patient Name: _____ Date of Birth ____/____/____
Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

1. Period of Medical Necessity: A. ___ New Prescription ___ Refill Prescription B. Order Start Date: ____/____/____
Estimated length of need: ____ Months

2. Equipment Prescribed: The following represents the least expensive equipment that will meet the patient's medical needs:
_____ E0570 Nebulizer With Compressor (e.g. Pulmoaide™ type) (for Medicare B Patients also complete F2F form for this item only)
_____ J7613 Albuterol 0.083% per ml unit-of-use ampules QTY/Month _____
_____ J7618 Albuterol concentrate 0.5% per ml, 20ml multi-dose vials QTY/Month _____
_____ J7644 Ipratropium 0.02% per ml unit-of-use ampules QTY/Month _____
_____ J7620 Duoneb 3ml unit-of-use vials QTY/Month _____
Other:_____

3. Pertinent Diagnosis (**ICD-10-CM Codes**): **Fill in all that apply**:
ICD-10-CM Code: _____ Asthma ICD-10-CM Code: _____ Emphysema
ICD-10-CM Code: _____ COPD ICD-10-CM Code: _____ Other

4. Please Answer the Following Questions:
A. Is the patient's ability to breathe severely impaired? **Yes** **No** B. Was the use of a MDI considered? **Yes** **No**
C. Equipment is for use in the patient's home? **Yes** **No** D. Why is a nebulizer medically necessary rather than a MDI?
_____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND: 1) Patient Name 2) Date Prescribed 3) Physician Signature 4) NPI. Medicare Part B patients are required to have a face to face encounter with a MD, APRN or PA in the six (6) months prior to the date of the written order for this type of durable medical equipment (DME). The face to face encounter must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the DME item(s) ordered. Please provide the following information:

Date of face to face encounter: ___/___/___ Performed by: _____ NPI: _____

Please provide a copy of the face to face examination records and complete this form so that we may provide this equipment to your patient.

By signing this statement, "The ordering physician/provider does hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. "I, the undersigned, certify that the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and are not being prescribed as "convenience" equipment.

Doctor Name: _____ **Prescriber NPI #:** _____
Street Address: _____**City, ST, Zip** _____
Signature: _____ **Date Signed:** ____/____/___
Signing Prescribers NPI # (If Different from above) _____