Medical Service Company

Nebulizer Order Form

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

Patient Name: _____ **Date Prescribed:** ____/____/____

Date of Birth: ____/____/____ **Length of Need: 99 months (lifetime) OR** ____ **# of months)**

Home Phone/Cell #: _____ **ICD-10 (Diagnosis):** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

NEBULIZER EQUIPMENT/SUPPLIES

☐ **Nebulizer with Compressor (E0570)**

The nebulizer will automatically include the supplies listed below. If your patient doesn't need any of them, cross out those items.

- Disposable Admin Set A7003 (2 per month)
- Non-Disposable Admin Set A7005 (1 per 6 months)
- Disposable Nebulizer Filter A7013 (2 per month)

MEDICATION

Medication Name: _____

☐ Doses: _____

☐ Frequency: _____

☐ Refills: _____

INCLUDE THIS DOCUMENTATION TO DISPENSE AND BILL:

☐ **Copy of the medical records that supports the diagnosis and need for the Nebulizer signed and dated by the Physician.**

Physician's Signature: _____ **Date:** ____/____/____

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____