Medical Service Company

Select Branch or Representative

NEBULIZER Fax Order Form

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

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

Address: _____ Length of need: _____99_____

City/Zip: _____ Diagnosis (check box): ☐ COPD ☐ Emphysema ☐ Asthma

Home Phone/Cell#: _____ ☐ Chronic Bronchitis ☐ Other: _____

Date of Birth: _____ ICD-10 Diagnosis Code:_____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

☐ **NEBULIZER (E0570) and all related supplies**

The ordered nebulizer will automatically come with the supplies listed below in order to operate the machine. If your patient does not need any of the below supplies please cross them out.

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

If your patient requires a mask for treatments, please check the box below.

☐ Nebulizer Mask A7015 (1 per 90 days)

Medication:_____ Frequency:_____ Doses:_____ Refills:_____

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

Physician's Printed Name: _____ Ph: _____ Fax: _____

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

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