Medical Service Company

Please fax completed form to 1-877-824-1411

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

Frequency of Usage _____

☐ Disposable Admin Set	☐ Non-Disposable Admin Set	☐ Disposable Nebulizer Filter	☐ Nebulizer Mask
A7003 (2 per month)	A7005 (1 per 6 months)	A7013 (2 per month)	A7014 (1 per 90 days)

NEBULIZER MEDICATIONS (to be administered via nebulizer as indicated below)

Please submit your nebulizer medication electronically to MSC Pharmacy or fax to (877) 373-3460.

☐ Acetylcysteine solution *(Mucomyst)*	☐ **10% OR** ☐ **20%** **Volume to be administered:** _____	Frequency:_____	Doses:_____	Refills:_____
☐ Albuterol solution	☐ **0.63mg/3ml OR** ☐ **1.25mg/3ml OR** ☐ **2.5mg/3ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Arformoterol solution *(Brovana)*	☐ **15mcg/2ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Budesonide suspension *(Pulmicort)*	☐ **0.25mg/2ml OR** ☐ **0.5mg/2ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Formoterol solution *(Perforomist)*	☐ **20mcg/2ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Ipratropium Br/Albuterol solution *(Duoneb)*	☐ **0.5mg/2.5mg/3ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Ipratropium solution *(Atrovent)*	☐ **0.5mg/2.5ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Levalbuterol solution *(Xopenex)*	☐ **0.63mg/3ml OR** ☐ **1.25mg/3ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Revefenacin solution *(Yupelri)*	☐ **175mcg/3ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Sodium Chloride solution	☐ **0.9% - 3ml OR** ☐ **0.9% - 5ml**	Frequency:_____	Doses:_____	Refills:_____
	☐ **3% - 4ml OR** ☐ **7% - 4ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Tobramycin solution *(Tobi)*	☐ **300mg/5ml**	Frequency:_____	Doses:_____	Refills:_____
☐ Other:_____		Frequency:_____	Doses:_____	Refills:_____

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

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

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

Name of Agent Completing Form: _____

www.MedicalServiceCo.com