TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: ______________________

Date of Order ______________________

Fax to (708) 293-1144

Nebulizer Form

PATIENT INFORMATION

Patient Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: ______________

Phone #: ______________________ Email: ______________________

DOB: ______________________ Height: ______________ Weight: ______________

PATIENT INSURANCE INFORMATION

Insurance Type: ☐Medicare ☐Medicaid ☐ Private Insurance ______________________

Insurance ID #: ______________________ Group # ______________________

It is not necessary to fill it out this section, if the order is accompanied by a copy of the patient's insurance card.

Diagnosis:

- ☐ Asthma
- ☐ COPD
- ☐ OSA
- ☐ Emphysema
- ☐ Chronic Bronchitis

Diagnosis Code ______________________

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes form the visit AND obtain a written order PRIOR to delivery that consists of the item.

☐ Face to Face Attached ☐ WOPD

Aerosol Therapy:

☐ Nebulizer with Compressor (E0570) ☐ Filters (A7013) – 2 per month ☐ Disposable Kit (A7003) – 2 per month

☐ Nebulizer Kit (A7005) – 1 every 6 months ☐ Mask (A7015) – 1 per month

Duration of Need 99 (Lifetime) unless otherwise noted: ______________________

Medication Prescribed ______________________

Dose ______________________ **Frequency** ______________________

PRESCRIBING PHYSICIANS INFORMATION

Physician Name: ______________________ NPI: ______________________

Physician Signature: ______________________ Date: ______________________

Physician Phone #: ______________________ Fax #: ______________________