847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Nebulizer OrderForm

Referral Source:_____ Referral Source Phone:(_____)_____

PATIENT'S INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____ Birth Date:_____/_____/_____

Sex: Female_____ Male_____

DIAGNOSIS INFORMATION

Certificate Medical Necessity Dx:

[ ] J40 Bronchitis, not specified as acute or chronic
[ ] J41.0 Simple chronic bronchitis
[ ] J42 Unspecified chronic bronchitis
[ ] J11.1 Influenza due to unidentified influenza virus with other respiratory manifestations
[ ] other, _____

Please check ICD-10 code

[ ] J12.9 Viral pneumonia, unspecified
[ ] J11.89 Influenza due to unidentified influenza virus with other manifestations
[ ] J47.9 Bronchiectasis, uncomplicated
[ ] J44.9 COPD, unspecified
[ ] E84.0 Cystic fibrosis with pulmonary manifestation
[ ] J45.20 Mild intermittent asthma, uncomplicated
[ ] J45.909 Unspecified, asthma, uncomplicated
[ ] A37.91 Whooping cough, unspecified

INSURANCE INFORMATION

Medicare Number:___ _____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy#:_____

Private Insurance Name:_____ Policy#:_____

PRODUCT(S) REQUESTED

[ ] Nebulizer E0570

[ ] Nebulizer Kit A7005

[ ] Nebulizer Mask A7015 Length of Need:_____ (1-99) 99=Lifetime

PHYICIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____