Nebulizer Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

NEBULIZER AND SUPPLIES:

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Date of Last Visit: _____

- ☐ Aerosol (Nebulizer) Machine (E0570)
- ☐ Disposable Filter (A7013) 2/month
- ☐ Mask Adult (A7015) 1/month
- ☐ Mask Pediatric (A7015) 1/month
- ☐ Mask, Trach (Nebulizer) (A7525) 1/month
- ☐ Reusable Neb Kit (A7005) 1 per 6 months OR Disposable Neb Kits (A7003) 2/month

Medication: _____

_____

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____