Ordering Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Equipment

**Please check boxes:**

* E050 Nebulizer Compressor
* A7005 Nebulizer Reusable Cup
* A7015 Mask

SN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Length of Need**:99 Months

Diagnosis:

* J45.909 Asthma
* R06.2 Wheezing
* Other 1CD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Medication is to be obtained at patient’s local pharmacy via separate prescription.\*

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to purchase the healthcare products/services from DME Living Well. I have received a copy of the DME Privacy Notice. I understand the information contained in the notice any questions were answered to my satisfaction. I authorize direct payment to DME Living Well, any insurance benefits otherwise payable to me for all services provided by them. I agree to transfer immediately to DME and payment made to me. I agree to pay any charges not covered. I have been given a list of providers to choose from for this equipment. I have received instructions from the referral staff on the safe operation and maintenance of this equipment. **E0570 Charge $89.99, A7005 Charge 29.99, A7015 $9.99.**

The signature below certifies that he/she has read the above writing, and is the patient or authorized by the patient as the patient’s general caregiver to sign and accept this agreement.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Attach Patient Demographic Sheet Along with Above Prescription, OR Information Below Needs to be Completed.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male  Female Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance:  Aetna  Anthem BCBS  United Health Care  Tricare  Medicaid  Other

Patient’s Policy ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance (if applicable):

 Aetna  Anthem BCBS  United Health Care  Other  Medicaid

Policy Holder’s ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note if Insurance Plan is not listed, do not complete this form. Contact our Intake Dept. at 860-674-1601. We are currently not participating Providers for Cigna, ConnectiCare,and Aetna plans.