Written Order for Medical Equipment

Patient Name: _____ Patient D.O.B: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Insurance Name: _____ Insurance Number: _____

Diagnosis: _____ Length of Need: _____ (99= lifetime)

_____

Base Equipment:

☐ E0570 Nebulizer Machine

Replace the following supplies as necessary at the intervals listed:

☐ A7003 Administration set, disposable (2 per month)

☐ A7005 Administration set, non-disposable (1 every 6 months)

☐ A7013 Filter, disposable (2 per month)

☐ A7015 Aerosol mask (1 per month)

Frequency of Use: _____

COMMENTS/Therapeutic Objectives: _____

_____

_____

_____

_____

Physician Attestation: I hereby authorize the use of this document as a legal prescription for the item indicated above. I certify that the above prescription is medically necessary and reasonable for the treatment of this patient.

Physician Name: _____ Physician NPI # _____

Physician Address: _____ Physician Phone: _____

Signature: _____ Date: _____