1-888-BINSONS
Fax: 586-755-2322

Nebulizer - Detailed Written Order Prior to Delivery

Patient Name ______________________________

Account Number ______________ Patient DOB ______________ Order Date ______________

☐ Face Sheet/Demographics/Chart Notes Attached

- Chart notes must include the need for equipment being ordered and **MUST BE ATTACHED FOR OVER QUANTITY**

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order**: ______________

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:
Reason for Medical Necessity (other than diagnosis): ______________________________

DIAGNOSIS (check applicable diagnosis below) **Length of Need:** ☐ 12 Months ☐ Other ________ 99 = Lifetime

☐	Asthma	☐	Cystic Fibrosis w/Pulmonary Manifestations
☐	Bronchitis	☐	Pneumonia
☐	COPD	☐	Other ______________________

NEBULIZER PRODUCTS

☐	Nebulizer w/ Compressor (E0570)
☐	Other ______________________________

ACCESSORIES – The following are medically necessary. (Cross of equipment/supplies not ordered)

☒	Disposable nebulizer set, 2 monthly (A7003)	☒	Reusable nebulizer set, 1 every 6 months (A7005)
☒	Aerosol mask, 1 monthly	☒	Disposable filter, 2 monthly (A7013)
☒	Reusable filter, 1 every 3 months (A7014)	☒	Disposable small volume nebulizer set, 2 monthly (A7004)

NEBULIZER SOLUTIONS/DOSE

☒	Albuterol Sulfate	Frequency ______________ X Daily
☐	Other	Frequency ______________ X Daily

OVERNIGHT PULSE OXIMETRY TEST ☐

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials ______________________________ NPI No. ______________

Telephone No. ______________________ Fax No. ______________________

Signature ______________________________ Signature Date ______________
(Stamped Signature Not Accepted)

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order.

This must be received by the supplier before equipment is dispensed.

A small volume nebulizer, related compressor and FDA approved inhalation solutions are covered when:

- It is reasonable and necessary to administer the drugs to a beneficiary:
    - For the management of obstructive pulmonary disease,
    - With cystic fibrosis,
    - With bronchiectasis,
    - With HIV, pneumocystis, or complications of organ transplants,

      or

    - For persistent thick or tenacious pulmonary secretions.

If none of the drugs used with a nebulizer are covered, the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary.

The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.