BINSON'S Medical Equipment & Supplies Since 1953

888-BINSONS
Fax: 586-755-2322

BECN 15279010387

Nebulizer Detailed Written Order Prior to Delivery

Patient Name:

Account #: Patient DOB:

☐ ***Face Sheet/Demographics Faxed***

Order Date

☐ ***Chart Notes Attached***
Chart notes must include the need for equipment being ordered.

☒ I, the Physician, have seen 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:**

DIAGNOSIS (check appropriate diagnosis below) Length of Need: ☐ 12 Month ☐ Other 99 = Lifetime

☐ Abnormal Sputum	☐ Cystic Fibrosis w/Pulmonary Manifestations
☐ Asthma	☐ Emphysema
☐ Bronchitis	☐ HIV
☐ Chronic Airway Obstruction	☐ Pneumocystis
☐ Complication of Transplanted Organ	☐ Pneumonia
☐ Congenital Bronchiectasis	☐ Tuberculosis
☐ COPD	☐ Other

Nebulizer Products

☐ Nebulizer with compressor (E0570) ☐ Other

The following accessories are medically necessary. (Cross off equipment/supplies not ordered)

☒ Disposable nebulizer Set, 2 monthly (A7003)	☒ Reusable Nebulizer Set, 1 every 6 months (A7005)
☒ Aerosol Mask, 1 monthly (A7015)	☒ 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 0.083% / 3 ml U/D	Frequency	____________	X Daily
☐ Ipratropium Bromide 0.02% / 2.5 ml U/D	Frequency	____________	X Daily
☐ Ipratropium / Albuterol 0.5 mg / 3 ml U/D	Frequency	____________	X Daily
☐ Cromolyn Sodium 20 mg / 2 ml U/D	Frequency	____________	X Daily
☐ Acetylcysteine 10%	Frequency	____________	X Daily
☐ Acetylcysteine 20%	Frequency	____________	X Daily
☐ Pulmicort Respules 0.25 mg / 2 ml U/D	Frequency	____________	X Daily
☐ Pulmicort Respules 0.5 mg / 2 ml U/D	Frequency	____________	X Daily
☐ Brovana 15 mg / 2 ml	Frequency	____________	X Daily
☐ Performist 20 mg / 2 ml	Frequency	____________	X Daily
☐ Other	Frequency		X Daily

Refills

☐ One Year ☐ Other

Quantity

☐ 30-Day Supply ☐ Other

Prescribing Physician's Information

Name & Credentials	NPI #
Telephone	Fax
Signature (Stamped signature not accepted)	Signature Date

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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 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.