

Nebulizer Detailed Written Order Prior to Delivery

Patient Name: Account #: Patient DOB: <input type="checkbox"/> Face Sheet/Demographics Faxed	Order Date <input type="checkbox"/> Chart Notes Attached <small>Chart notes must include the need for equipment being ordered.</small>
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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:	<input type="checkbox"/> 12 Month	<input type="checkbox"/> Other	99 = Lifetime
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cystic Fibrosis w/Pulmonary Manifestations				
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema				
<input type="checkbox"/> Chronic Airway Obstruction	<input type="checkbox"/> HIV				
<input type="checkbox"/> Complication of Transplanted Organ	<input type="checkbox"/> Pneumocystis				
<input type="checkbox"/> Congenital Bronchiectasis	<input type="checkbox"/> Pneumonia				
<input type="checkbox"/> COPD	<input type="checkbox"/> Tuberculosis				
	<input type="checkbox"/> Other				

Nebulizer Products	
<input type="checkbox"/> Nebulizer with compressor (E0570)	<input type="checkbox"/> Other

The following accessories are medically necessary. (Cross off equipment/supplies not ordered)	
<input checked="" type="checkbox"/> Disposable nebulizer Set, 2 monthly (A7003)	<input checked="" type="checkbox"/> Reusable Nebulizer Set, 1 every 6 months (A7005)
<input checked="" type="checkbox"/> Aerosol Mask, 1 monthly (A7015)	<input checked="" type="checkbox"/> Disposable Filter, 2 monthly (A7013)
<input checked="" type="checkbox"/> Reusable Filter, 1 every 3 months (A7014)	<input checked="" type="checkbox"/> Disposable Small Volume Nebulizer Set, 2 monthly (A7004)

Nebulizer Solutions/Dose	
<input type="checkbox"/> Albuterol Sulfate 0.083% / 3 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Ipratropium Bromide 0.02% / 2.5 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Ipratropium / Albuterol 0.5 mg / 3 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Cromolyn Sodium 20 mg / 2 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Acetylcysteine 10%	Frequency _____ X Daily
<input type="checkbox"/> Acetylcysteine 20%	Frequency _____ X Daily
<input type="checkbox"/> Pulmicort Respules 0.25 mg / 2 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Pulmicort Respules 0.5 mg / 2 ml U/D	Frequency _____ X Daily
<input type="checkbox"/> Brovana 15 mg / 2 ml	Frequency _____ X Daily
<input type="checkbox"/> Performist 20 mg / 2 ml	Frequency _____ X Daily
<input type="checkbox"/> Other	Frequency _____ X Daily

Refills	
<input type="checkbox"/> One Year	<input type="checkbox"/> Other

Quantity	
<input type="checkbox"/> 30-Day Supply	<input type="checkbox"/> Other

Prescribing Physician's Information	
Name & Credentials	NPI #
Telephone	Fax
Signature	Signature Date
<small>(Stamped signature not accepted)</small>	

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.

MICHIGAN LOCATIONS
CENTER LINE

Corporate & Retail Location
26834 Lawrence
Center Line, MI 48015
586-755-2300
888-BINSONS
Fax: 586-755-2322

DEARBORN

5250 Auto Club Dr

EASTPOINTE

21571 Kelly Rd

FARMINGTON HILLS

Tri-Atria Building

32255 Northwestern Hwy

FLINT

G-4433 Miller Rd

LIVONIA

13450 Farmington Rd

LIVONIA

St. Mary Mercy Hospital

36475 5 Mile Rd

ROYAL OAK

30475 Woodward Ave

SAGINAW

5599 Bay Rd

SOUTHGATE

18800 Eureka Rd

STERLING HEIGHTS

43900 Schoenherr Rd

TROY

6475 Rochester Rd

FLORIDA LOCATIONS

LONGWOOD

830 S. Ronald Reagan Blvd

866-928-0003