MEDI-RENTS & SALES INC.

800-540-7252

Referred by: Name_____

Office_____

Phone #_____

Nebulizer

Physician Order/Prescription

START DATE____/____/_____

Fax completed form with Physician's Signature and Supporting Documentation to 844-825-3613

Patient Information

Patient Name: Date of Birth: Gender M / F

Patient Phone #: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance & ID# Group # Social Security #:

Medicaid #: Secondary Insurance:

ORDER DELIVERY DATE____/____/_____

FUNCTIONAL LIMITATIONS_____FAMILY AND SUPPORT SYSTEM ☐ YES ☐ NO

ABILITY TO USE AND CARE FOR EQUIPMENT ☐ GOOD ☐ NEEDS HELP SUITABLE ENVIRONMENT ☐ YES ☐ NO

Products to Dispense (check all that apply)

(1)___Nebulizer Compressor E0570 (4) ___Misty Tee A7003 used daily/changed weekly (4)___Mask A7003 used daily/changed weekly

(1)___Filters A7013 used daily/changed monthly Type: ___Adult ___Infant ___Pediatric Frequency of Use: _____

Diagnosis Information (check all that apply)

☐ **J45.909 Asthma Unspecified** ☐ **J40 Bronchitis** ☐ **E84.19 Cystic Fibrosis**

☐ **J98.4 Chronic Lung Disease** ☐ **Other**_____

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

Medical Justification: _____

Date last seen: ____/____/_____ Prognosis:_____

Physician Information

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI#: _____ License #: _____ Exp Date: ____/____/____ (MM / DD / YY)

Physician's Signature _____ **Date** ____/____/____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

medirents.net

Approved By ACHC