



**PHONE: 1.800.344.1550 FAX: 1.844.317.9377**  
**EMAIL: orders@chcsolutions.com**

**NEBULIZER ORDER FORM**

**\*\*Please attach face sheet w/ patient demographics & insurance info\*\***

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
Language Pref.:  English  Spanish  Other: \_\_\_\_\_ Patient cannot accept deliveries on the following days?  
Mon Tues Wed Thurs Fri Sat

**DIAGNOSIS**

<b>Primary Diagnosis</b> ICD-10 Code: _____ <small>*Non-Specified Codes will not qualify for Primary Diagnosis</small>	<b>Secondary Diagnosis</b> ICD-10 Code: _____
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**PRODUCTS**

- Nebulizer/Compressor
- Mask (Adult)
- Mask (Pediatric)
- Mouthpiece (Adult)
- Portable Nebulizer (Must have LMN for Authorization)
- Other

Please List Medications below (or attach with this order)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Length of Need: \_\_\_\_\_ months

**REFERRAL INFORMATION**

Ref #: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
Office Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email  
Contact Person: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_