

****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
 Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis

ICD-10 Code: _____

*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis

ICD-10 Code: _____

PRODUCTS

	QUANTITY
<input type="checkbox"/> Nebulizer with Compressor	
<input type="checkbox"/> Adult Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Adult Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Pediatric Reusable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Pediatric Disposable Nebulizer Kit (Includes administration set and aerosol mask)	
<input type="checkbox"/> Reusable Administration Set	
<input type="checkbox"/> Disposable Administration Set	
<input type="checkbox"/> Adult Aerosol Mask	
<input type="checkbox"/> Pediatric Aerosol Mask	
<input type="checkbox"/> 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, 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.

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.