



PHONE: 1.800.344.1550 FAX: 1.844.317.9377
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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

Primary Diagnosis

ICD-10 Code: _____

*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis

ICD-10 Code: _____

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: ____/____/____