FAX BACK TO 805-435-0432

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PRESCRIPTION FOR NEBULIZER

Patient Information or Attach Demo Sheet

Patient Name:	
Sex:	☐F or ☐M
Address:	
City-State-Zip:	
Phone#:	
Email:	
Insurance:	
Ins Member ID:	
DOB:	

Attending Physician Information

Physician's Name:	
Address:	
City-State-Zip:	
Phone#:	
Fax#:	
NPI #:	
DATE:	
Physician Signature:	**X**_____ ***/****

*** I certify the medical necessity of these items for this patient. This form has been completed by me. The foregoing information is true, accurate, and complete. I also certify that the patient is aware that they will be contacted by Remedy Medical Supply regarding this prescription**

**** I am prescribing the following:** **Length of need is 99 unless otherwise indicated _____.**
Dx Code(s): _____

1 E0570 Nebulizer Compressor Kit and ongoing supplies as needed.

Compressor, 1 A7005 nebulizer and all necessary tubing and attachments, and User Manual

Choose options below

☑ 1 A7005 Reusable Nebulizer Kit per 6 months

☐ 1 A7015 Aerosol Mask per month

☐ Any or ☐ Brand_____ Model _____

Please include chart notes supporting the diagnosis, drugs being ordered for nebulization, and the need for a nebulizer.