Nebulizer

Stand Written Order (SWO)

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Nebulizer and Supplies

- ☐ **Nebulizer Small Volume - E0570**
- ☐ **Nebulizer Set Disposable - A7003 - Dispense 2 per month**
- ☐ **Nebulizer Set Non Disposable - A7005 - Dispense 1 every 6 months**
- ☐ **Filter, Disposable used with Nebulizer - A7013 - Dispense 2 per month**
- ☐ **Aerosol Mask - A7015 - Dispense 1 per month**

Required Medication Information

Please provide the Nebulizer Medication and Unit Dosage.

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES , i.e. doctors, progress,and or nurses notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date/signature date of this form be the same or after the date on the Clinical Notes and Face to Face.

Coverage Criteria

A small volume nebulizer (A7003, A7005), related compressor (E0570) are covered when:

a. It is reasonable and necessary to administer albuterol (J7611, J7613), arformoterol (J7605), budesonide (J7626), cromolyn (J7631), formoterol (J7606), ipratropium (J7644), levalbuterol (J7612, J7614), or metaproterenol (J7669) for the management of obstructive pulmonary disease, or

b. It is reasonable and necessary to administer dornase alpha (J7639) to a beneficiary with cystic fibrosis, or

c. It is reasonable and necessary to administer tobramycin (J7682) to a beneficiary with cystic fibrosis or bronchiectasis, or

d. It is reasonable and necessary to administer pentamidine (J2545) to a beneficiary with HIV, pneumocystosis, or complications of organ transplants, or

e. It is reasonable and necessary to administer acetylcysteine (J7608) for persistent thick or tenacious pulmonary secretions.

If the criteria are not met, or proper documentation is not received the nebulizer and supplies will be denied as not medically necessary.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.