Home Medical Equipment and Oxygen
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave. • Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 •FAX: (740) 652-9253

Fax Number:__________
Pages:__________

Dear Doctor, **Date:**

Below is confirmation of the Physician's Order for Aerosol Nebulizer and Supplies

Patient's Name____

Initial Date:_________ **Renewal Date**____________ **Height**____________________ **Weight**___________

Diagnosis (include ICD-9 Code)____
I certify that the following equipment is medically necessary:

AEROSOL NEBULIZER and/or SUPPLIES: **To administer the following** Medications:

The following are the only medications currently available for Medicare Part B Reimbursement:

Albuterol 0.083%/ 3 ml.	**BID**	**TID**	**QID**	**Q4H**
Levalbuterol (Xoponex) 1.25 mg. (3 ml)	**BID**	**TID**	**QID**	**Q4H**
Ipratropium Br. 0.02% / 2.5 ml.	**BID**	**TID**	**QID**	**Q4H**
Metaproteronol 0.6% / 2.5 ml	**BID**	**TID**	**QID**	**Q4H**
Cromolyn 20 mg/2ml solution	**BID**	**TID**	**QID**	**Q4H**
Pulmicort 0.5 mg. / 2 ml	**BID**	**TID**	**QID**	**Q4H**
DuoNeb (albuterol 2.5 mg, ipratropium 0.5 mg.)	**BID**	**TID**	**QID**	**Q4H**

Medications billable for Medicare Part B Reimbursement for patients with specific diagnoses:

acetylcysteine (Mucomyst 20%) **BID** **TID** **QID** **Q4H**
Patient has persistent thick or tenacious secretions: (ICD-9 480.0 – 508.9 and 786.4)
Additional Diagnosis:___________________________

TOBI 300mg/5ml **TID** **QID** **Q4H**
Patient has diagnosis of bronchiectasis or cystic fibrosis; Diagnosis______________________________
Treatment Frequency: **BID** **TID** **QID** **Q4H**
Q6H **Other**

Supplies: **Reusable PARI nebulizer or equivalent (2/year)** Recommended.
Disposable neubulizer sets

LENGTH OF USE: **Lifetime** **Months**

The clinical information noted above was provide to us by you; your staff; hospital:___________________________________

By signing my signature below, I certify that I have ordered the items listed above for the named beneficiary.

Physician Signature_______________________**Date**___________
Physician Name___________________ **NPI** ___________
Please return this order *via Fax* to: ___ (740) 385-0474 (Logan) ___ (740) 652-9253 (Lancaster)