PROFESSIONAL MEDICAL HOME HEALTHCARE

4859-C MEMORIAL DR.
STONE MOUNTAIN, GA 30083
PHONE 404.292.919
FAX 404-508-9225

PRESCRIPTION ORDER FOR NEBULIZER

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ DOB _____

CONFIRMATION OF ELIGIBILITY; PLEASE PROVIDE PATIENTS DIAGNOSIS AND MEDICAL CONDITION (S).

☐ CMN · MEDICAL NECESSITY:

Patient's Diagnosis _____ Medicaid No. _____

Patient's Medical Condition: _____ Medicare No. _____

Prescription Order Duration: _____ Other Insure. _____

Date Card Issued: _____ Expires: _____

Physician Verification

I have reviewed this patient's medical records and the items ordered above. I verify that these products are medically necessary for the patient's condition. I further verify that the diagnosis information, provided on this prescription order is an accurate statement of this patient's conditions referenced in the patient's medical chart on file.

Physician's Signature _____ Date: _____

Physician Name _____ Address: _____

License Number _____ City: _____ State: _____

NPI Number: _____ Telephone Number: _____

PATIENT'S Signature of Receipt: _____

Equipment Serial Number: _____

Please **Do Not dispense Nebulizers to patients who have received one in less than **3** years.**