DOUBEK medical supply

TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: _____

Referral #: _____

Fax to (708) 293-1144

Nebulizer Form

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

DOB: _____ Height: _____ Weight: _____

PATIENT INSURANCE INFORMATION

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance _____

Insurance ID #: _____ Group # _____

It is not necessary to fill it out this section, if the order is accompanied by a copy of the patient's insurance card.

Diagnosis:

☐ Asthma
☐ COPD
☐ OSA
☐ Emphysema
☐ CHF
☐ Chronic Bronchitis
☐ Other Diagnosis _____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes form the visit AND obtain a written order PRIOR to delivery that consists of the item AND:

1) Patient Name
2) Date Prescribed
3) Physician Signature
4) NPI

☐ Face to Face Attached ☐ WOPD

Aerosol Therapy:

☐ Nebulizer with Compressor (E0570)
☐ Nebulizer Kits (A7005)
☐ Mask (A7015)
☐ Duration of Need 99 (Lifetime) unless otherwise noted: _____

PRESCRIBING PHYSICIANS INFORMATION

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Physician Phone #: _____ Fax #: _____

Please FAX completed form to 708-293-1144

THANK YOU FOR YOUR ORDER!