Complete and print.

Reset Form

MAYO CLINIC

# *Nebulizer Supplies Prescription*

**Mayo Clinic Store**

Form content not retained in medical record.
**Route to Mayo Clinic Store for electronic storage.**

*(complete fields or place patient label here)*

| |
|---|
| Patient Name *(First, Middle, Last)* |
| Birth Date *(mm-dd-yyyy)* |
| Mayo Clinic or Store Account Number |

**External Form Users:** Complete this document and fax to the Mayo Clinic Store.

**Internal Epic Downtime Form Users:** Complete this document and fax to the Mayo Clinic Store. Once Epic downtime processes are complete, reenter order into the EHR and send an Epic message to the Mayo Clinic Store's inbasket pool informing them that a duplicated order was created.

**Required:** Attach patient's current primary, secondary, and tertiary insurance providers and provider-signed clinical documentation verifying medical justification from face-to-face examination.

## Medicare Requirements

- Communication occurs between the provider and patient sometime during the 6 months prior to an order for and delivery of the item
- Documentation includes need for the item and beneficiary was evaluated and/or treated for a condition supporting the need for the nebulizer ordered
- Medical justification is required to support prescription
- Allows dispensing of one nebulizer compressor every 5 years

## Order Information

| | | |
|---|---|---|
| Order Date *(mm-dd-yyyy)* | Start Date *(mm-dd-yyyy)* | Need Length ☐ Lifetime ☐ Other_____ |
| Qualifying Diagnosis (ICD-10) | | Date of Face-to-Face Examination *(mm-dd-yyyy)* |
| Patient Address *(Street, City, State, ZIP Code)* | | Patient Phone |

## Supplies

☐ Nebulizer machine filters, two per month – lifetime (A7013)
☐ Nebulizer disposable kit, two per month – lifetime (A7003)
☐ Nebulizer permanent kit, one every 6 months – lifetime (A7005)
☐ Nebulizer mask, one per month – lifetime (A7015)
Select one: ☐ Adult ☐ Pediatric ☐ Infant
☐ Other _____

Special Instructions

## Referring Provider Information and Signature

| | | |
|---|---|---|
| Facility | Phone | Fax |
| Provider Signature ▶ Signature Required | Date *(mm-dd-yyyy)* | |
| Provider Printed Name *(First, Middle, Last)* | National Provider Identifier | |

Print

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.