CERTIFICATE OF MEDICAL NECESSITY FOR NEBULIZERS
(To be completed by the licensed practitioner or the provider based upon documentation of medical necessity by the licensed practitioner)

I certify that the information on this form is true and correct	
Licensed Practitioner Signature:	Date:
Licensed Practitioner Name (please print):	Licensed Practitioner License Number:
Licensed Practitioner Address:	Licensed Practitioner Phone Number:
Patient Diagnosis (specific and complete): Severity of reversible airway obstruction: ❑ Mild ❑ Moderate ❑ Severe	[ ] Recommend PURCHASE of Nebulizer Compresor

Patient Name:	Client Identification Number (CIN):	Date of Birth:
Provider Name and Address: ADVANCED HOME MEDICAL INC 312 PASEO TESORO, WALNUT CA 91789 (909) 569-9013		Provider ID Number: DME02989G National Provider Identifier (NPI):1275587685
Date of service:	Length of need: 99 MONTHS	

Dates for past 12 months for above diagnosis(es):

Acute Hospital Admission(s):_____

ER/Urgent Clinic Visits:_____

Office Visits:_____

Have metered dose inhalers been utilized? _____

Have spacers been utilized? _____

If yes, results?_____

If no, why not?
_____

Current prescriptions for inhaled medications (Name and dose):

FAX COMPLETED FORM TO: 888-518-7568