CERTIFICATION FOR NEBULIZER

Professional Medical HHC
4859-C Memorial Drive
Stone Mountain, GA 30083
404-292-9190
404-508-9225 Fax

Does not require prior approval starting 10/01/99

HPES
P.O. Box 105200
Tucker, GA 30085-5200

Member Medicaid Number ______________ Date of Birth __________
Member Full Name ______________________________

Diagnosis * ______________________________
***<u>Diagnosis must be respiratory or cardiac related</u>. Diagnoses such as the "respiratory illness" or "difficulty breathing" do not give reviewer enough information as to why member needs a nebulizer. Do not use symptoms such as wheezing, shortness of breath, or cough as diagnoses.**

Name of medication(s) to be administered with nebulizer:
____

- Dose: ______________
- Frequency: ______________

Condition is: ☐ Acute (Usually indicates need for rental)
☐ Chronic (Usually indicates need for purchase)
Prognosis of member: ☐ GOOD ☐ FAIR ☐ POOR
How long will member need this equipment? ________ months

For heated humidifier with compressor (E0585 RR)
Diagnosis requiring equipment ______________________
Does member have a tracheostomy? ☐ Yes ☐ No

For ultrasonic nebulizer E0575 RR or E0575 NU
Is diagnosis AIDS or AIDS related? ☐ Yes ☐ No
Is the medication being used Pentamidine? ☐ Yes ☐ No

I CERTIFY THAT THIS NEBULIZER IS MEDICALLY NECESSARY:

Physician Signature* ______________ Date __________
Physician's Printed Name ______________________
Address ______________________
***Stamped or computerized signatures or dates are not acceptable**

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