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:		
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Licensed Practitioner Name (please print):	Licensed Practit	ioner License Number:	
Licensed Practitioner Address:	Licensed Practit	Licensed Practitioner Phone Number:	
Patient Diagnosis (specific and complete):			
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Severity of reversible airway obstruction: Mild			
□ Moderate			
Severe	1		
Patient Name:	Client Identification Number (CIN):	Date of Birth:	
Provider Name and Address:		Provider ID Number:	
		National Provider Identifier	
	1	(NPI):	
Date of service:	Length of need:		
Dates for past 12 months for above diagnosis(es):			
Acute Hospital Admission(s):			
ER/Urgent Clinic Visits:			
Office Visits:			
Have spacers been utilized?			
If yes, results?			
If no, why not?			
Current prescriptions for inhaled medications (Name and dose):			