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

Patient Name:	Client Identification Number (CIN):	Date of Birth:
Provider Name and Address:		Provider ID Number:
		National Provider Identifier (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 metered dose inhalers been utilized? _____

Have spacers been utilized? _____

If yes, results?_____

If no, why not?
_____

Current prescriptions for inhaled medications (Name and dose):