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 Address:	Licensed Practitioner NPI Number: Licensed Practitioner Phone Number: Licensed Practitioner Fax Number:

Patient Diagnosis (specific and complete):

Severity of reversible airway obstruction:
- Mild
- Moderate
- Severe

Patient Name:	Client Id No: CIN	Date of Birth:
Provider Name and Address: **CALIFORNIA MEDICAL PHARMACY** **2201 W. TEMPLE STREET** **LOS ANGELES, CA 90026**	**PH:213-413-2343** **FAX:213-413-2341** **Contact Name** **Ext.**	National Provider Identifier (NPI): **1770583387**

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): FILL THESE MEDS PT HAS MEDS

ALBUTEROL 0.083%	SIG:
PULMICORT 0.25% OR 0.5%	SIG:
IPRATROPIUM BR 0.2%	SIG:
OTHER	

Email address:

"I, , hereby attest that the medical record entry for accurately reflects signatures/notations that I made in my capacity as when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."