APPENDIX P

CERTIFICATION FOR NEBULIZER

Does not require prior approval starting 10/01/99

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number ____________________ Date of Birth ______________
Member Full Name ____

Diagnosis * ____

*__Diagnosis must be respiratory or cardiac related__. **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 signatures or dates are not acceptable**