Jayhawk Pharmacy Services

Patient Supply
2620 SW 6th Ave.
Suite "E"
Topeka, KS 66606
785-235-9700`
785-235-9703 Fax
NPI: 1033397716

Pharmacy & Patient Supply
2860 SW Mission Woods Drive
Topeka, KS 66614
785-228-9700
785-228-1375 Fax
NPI: 1104852672

Custom Prescription Center
6730 SW 29th
Topeka, KS 66614
785-228-9740
800-338-9700

Medicare Requirements for Nebulizer

A small volume nebulizer (A7003,A7004,A7005) , related compressor (E0570) and FDA-approved inhalation solutions of the drugs listed below are covered when:

a. It is reasonable and necessary to administer albuterol (J7611, J713), arformoterol (J7605), budesonide (J7626), cromolyn (J7631), formoterol (J7606), ipratropium (J7644), levalbuterol (J7612, J7614), or metaproterenol (J7669) for the management of obstructive pulmonary disease (Reference ICD-9 Codes that Support Medical Necessity Group 8 Codes section for applicable ICD-9 diagnoses); or
b. It is reasonable and necessary to administer dornase alpha (J7639) to a beneficiary with cystic fibrosis (Reference ICD-9 Codes that Support Medical Necessity Group 9 Codes section for applicable ICD-9 diagnoses); or
c. It is reasonable and necessary to administer tobramycin (J7682) to a beneficiary with cystic fibrosis or bronchiectasis (Reference ICD-9 Codes that Support Medical Necessity Group 10 Codes section for applicable ICD-9 diagnoses); or
d. It is reasonable and necessary to administer pentamidine (J2545) to a beneficiary with HIV, pneumocystosis, or complications of organ transplants (Reference ICD-9 Codes that Support Medical Necessity Group 4 Codes section for applicable ICD-9 diagnoses); or
e. It is reasonable and necessary to administer acetylcysteine (J7608) for persistent thick or tenacious pulmonary secretions (Reference ICD-9 Codes that Support Medical Necessity Group 7 Codes section for applicable ICD-9 diagnoses).

Compounded inhalation solutions (J7604, J7607, J7609, J7610, J7615, J7622, J7624, J7627, J7628, J7629, J7632, J7634, J7635, J7636, J7637, J7638, J7640, J7641, J7642, J7643, J7645, J7647, J7650, J7657, J7660, J7667, J7670, J7676, J7680, J7681, J7683, J7684, J7685, and compounded solutions billed with J7699) will be denied as not reasonable and necessary.

If none of the drugs used with a nebulizer are covered, the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

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****Please be aware that you will be responsible for any co-payment or deductible amount that your insurance requires. ****

Today's Date ___/______/_____ *****PLEASE PRINT*****

Patient Name ______________________________ Date of Birth___/____/____

Address ____________________________ City___________________________

Zip__________ County_________________ (required) SSN ____________________

Phone number_________________ Cell/work number___________________

Parent name or legal guardian____

Parent name or legal guardian DOB:_____/_____/______

Card Holders Name____

Card Holders Birthday ___/______/_____ (required for insurance)

ICD-9 Diagnosis Code ____________ Length of Need__________ Months (Lifetime = 99)

Physician__________________________ _________________________

Signature Print

Nebulizer Therapy

_X__ Nebulizer Compressor Model: _______________ Serial # ________________

(Which includes Nebulizer kit and filter)

Required Documentation

- **Insurance Information (copy both Prescription and Medical Cards)**
- **Copy of Prescription with Rx signed by Physician**
- **Signature of patient or caregiver receiving Nebulizer** (below)

I realize if equipment or supplies are the same or similar to the equipment or supplies previously received, the insurance may not pay and I will be responsible. I certify that **I HAVE NOT** received same or similar equipment from another provider within the past 5 years**. Initial** _______

YES, I HAVE RECEIVED same or similar item from_______________ when:_________

Type of equipment: ________________ (I will be responsible for this payment)

I authorize the release of any medical information necessary to process any claims. I understand that I am solely responsible for my account regardless of insurance coverage. Jayhawk Pharmacy Services Inc. may contact me by phone or written correspondence with information about my health care needs.

I have been given a copy of HIPPA, Patient Bill of Rights, 30 DMEPOS Supplier Standards Complaint Procedure, and company contact information. For **Medicaid Beneficiaries**: This constitutes advance notice to you, the beneficiary, that if all program requirements are met by Jayhawk Pharmacy Services Inc. and payment is not made by KMAP, you may be held responsible for the charges.

Patient / Caregiver Signature _______________________________ Date:_______________

Relationship ____________________________________

We are contracted providers with BCBS, Medicare, Medicaid, Preferred Health, Century, Amerigroup of KS, Sunflower State,UnitedHealthcare Community Plan of Kansas.

This form needs to be completed in full to insure that the patient gets maximum insurance coverage.