

# Nebulizer Detailed Written Order / Delivery Request

Supplier Address: 2130 W. Jefferson, Joliet, IL 60435  
 Supplier Phone: (815) 725-1102  
 Supplier NPI: 1093720633  
 Supplier Tax ID: 36-3488554

Date: \_\_\_\_\_

<b>Patient Information (Mother Only)</b>		<b>Delivery/ Shipping Info, If different</b>	
<b>First Name:</b>	<b>MI:</b>	<b>Ship to Name: (if different)</b>	
<b>Last Name:</b>		<b>Address:</b>	
<b>Address:</b>		<b>Unit/Apt:</b>	
<b>Unit/Apt:</b>		<b>City, State, Zip:</b>	
<b>City, State, Zip:</b>			
<ul style="list-style-type: none"> <li>● <b>Cardholder's DOB:</b></li> <li>● <b>Cardholder's Name:    Patient's DOB:</b></li> <li>● <b>Mobile Phone:</b></li> <li>● <b>I, the patient, agree to receive text messages from Basinger's pharmacy. I understand Basinger's Pharmacy will text me only if additional information is needed to process my breast pump order. I understand all text messages will stop upon completion of my breast pump order, or if I text STOP to opt out at any time. I may also text HELP for assistance. Message and data rates may apply.</b></li> <li>● <b>Patient Signature:</b></li> </ul>			
<b>Insurance information (Please attach a copy of insurance card)</b>		<b>Commercial HMO's require pre-authorization</b>	
<b>Primary:</b>	<b>ID:</b>	<b>Group:</b>	<b>Referral #:</b>
<b>Secondary:</b>	<b>ID:</b>	<b>Group:</b>	<b>HMO's require referral/pre-auth</b>
<b>Clinic Information</b>		<b>Please print prescribing physician's name and NPI</b>	
<b>Provider first name:</b>	<b>Last:</b>	<b>NPI:</b>	
<b>Clinic name:</b>		<b>Phone:</b>	
<b>Address:</b>		<b>Suite:</b>	
<b>State:</b>	<b>City:</b>	<b>Zip:</b>	
<b>Certificate of Medical Necessity</b>		<b>All fields to be completed by Provider</b>	
<b>Fax to Basinger's Pharmacy with a copy of insurance card and HMO pre-authorization - (815) 725-1844</b>			
<b>Provider Signature:</b>		<b>Provider Credentials:</b>	
		<b>Signature date:</b>	
<u>Equipment prescribed</u>	<u>QTY</u>	<u>Frequcy of use</u>	<u>Length of need</u>
Nebulizer (E0570)	(1)	1 unit / 5 years	99 months - purchase only
Administrator Set Disposable (A7003)	(2)	2 unit / 30 days	99 months - purchase only
Administrator Set Permanent (A7005)	(1)	1 unit / 180 days	99 months - purchase only
Aerosol Mask for Nebulizer (A7015)	(1)	1 unit / 30 days	99 months - purchase only
Filter Disposable (A7013)	(2)	2 unit / 30 days	99 months - purchase only
<b>Start date of order:</b>		<b>Pump serial number:</b>	
		<b>Brand/Model number:</b>	
<b>Dx: (circle)</b>	<b>Unspecified asthma, Uncomplicated j45.909</b>	<b>Bronchitis, Unspecified j40</b>	<b>Chronic bronchitis Unspecified j41.0</b>
		<b>Bronchiectasis Uncomplicated j47.9</b>	<b>Viral pneumonial Unspecified j12.9</b>
	<input type="radio"/> Unless specified here:		
<b>Brief narrative of medical necessity / directions for use: (include name of medication / frequency of treatment - medication is not supplied by Basinger's, this is a CMS requirement)</b>			
<b>Need patients chart notes.</b>			

# Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500

## Medication Transfer Sheet/Release of Responsibility

Name of Facility: \_\_\_\_\_

Name of Resident: \_\_\_\_\_

Date of Release: \_\_\_\_\_

Expected Date of Return: \_\_\_\_\_

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:
  - a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.
  - OR
  - b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.
  - OR
  - c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: \_\_\_\_\_

Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of person returning unused medications: \_\_\_\_\_

Staff signature of count on return: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_