Please Fax This Form & F2F notes to Eastern Sleep & Respiratory at 866.203.5459

Nebulizer Delivery Ticket / Prescription

Patient Information

Last Name : _____FIRST: _____ DOB :_____ Street Address : _____ City : _____ State:_____ Zip:_____

Responsible Party :

Last Name : _____FIRST: _____ DOB :_____

Phone :_____ Cell:_____ Email :_____

Insurance information:

Primary : _____ID # _____Secondary : _____ID # _____

Has this patient Received Nebulizer last 5 Years YES * NO

*Please do not Dispense Nebulizer Call Easter Sleep & Respiratory 857-400-0044

Diagnosis:

☐ RAD(J45.20) ☐ Asthma (J45.909)

☐Other (ICD10 Code) _____ Length of Need _____

Equipment Dispensed

Nebulizer Compressor (E0570) w/ Disposable Neb (A7003) & Reusable Neb (A7005) & Filters(A7013) & Pediatric Mask A7015

Physicians Name :

Physicians Signature Date Office Dispensing : 1010 -QPA (Quincy)

We require all our patients to provide a form of payment to pay for any amounts their insurance does not cover. If you have provided insurance coverage to us, we will bill your insurance company; once the insurance company has issued a remittance regarding your account, we will charge your credit card for any remaining balance. We will email you a copy of the invoice and payment detail.

Assignment of Benefits

I hereby assign all medical and durable medical equipment benefits authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment(s) directly to Eastern Sleep Therapy, LLC d/b/a Nebulizer Care Club and Eastern Pulmonary Services, Inc. d/b/a Nebulizer Care Club for medical equipment and/or services rendered to myself and/or my dependents. I understand that I am financially responsible for any amount not covered by insurance and that I am waiving any anti-assignment clauses that are written into my health care contract. I have requested that the office of NSR be my agent in the filing, processing, and appealing of claims related specifically to medical equipment and/or services rendered by this office and that they may, but are not required, to appeal any rejected claims.

I understand that I have the opportunity to submit my bills directly to my health insurance carrier but have chosen to have the claims submitted by and paid directly to the office of NSR with accompanying explanation of benefits.

I authorize ESR to execute transactions on the above account. I consent to the use of the above payment method without my signature on the individual transactions in satisfying my obligations to ESR. I understand that an electronic copy of this agreement will serve as an original, and this payment authorization cannot be revoked.

_____ _____ _____

Date: Patient/ Caregiver Signature Relationship