Sherwood Clinical
DME Solutions

P: 800-847-3987 • F: 706-894-2806 • www.sherwoodclinical.com

*Date ______________________ Referral completed by ______________________

Patient Name ______________________ DOB __________ Male ______ Female ______

Address ______________________ City __________ State ______ Zip ______

Responsible Party (parent, legal guardian)______________________

Home______________ Work ______________ Cell ______________

Emergency Contact other than patient or guardian ______________________

Relationship ______________________ Phone #______________

Medicare #______________ Medicaid #______________ Self Pay ______________

Please provide enlarged copy of Insurance Card

Commercial Insurance Company ______________________ Phone # ______________

Member ID / Policy # ______________________ Group # ______________

Statement of Medical Necessity

I certify that it is medically necessary, based on the below diagnosis, for this patient to receive the following equipment/ supplies: compressor with nebulizer (E0570), reusable neb cup (A7005), and aerosol mask (A7015)

Please Circle Dx:

Asthma	Bronchitis		Bronchiolitis	Bronchospasm	COPD	Cough	Croup	Pneumonia
J45.20	J20.0	J20.6	J21.0	J98.01	J44.9	R05	J05.0	J18.8
J45.30	J20.1	J20.7	J21.1	J39.8				J18.9
J45.40	J20.2	J20.8	J21.8	J98.09				J15.9
J45.50	J20.3	J20.9	J21.9					
J45.909	J20.4	J40						
J45.998	J20.5							

URI	RSV	Shortness of Breath	Wheezing	Other:
J06.9	B97.4	R06.02	R06.2	__________
				__________

Equipment Rx for compressor, nebulizer kit and /or aerosol mask

***Physician Signature (ONLY)** ______________________ Date ______________

Physician Printed Name ______________________ Office Name ______________________

Address ______________________ City ______________ State ______ Zip ______

Phone ______________________ Fax ______________________

License # ______________________ NPI # ______________________

By signing below, I am authorizing Sherwood Clinical to release required medical information to insurer(s) for the purpose of reimbursement. I also acknowledge receipt of the nebulizer compressor and supplies.

*Responsible Party Signature ______________________ Date ______________