This form is intended as a reference tool for prescribers to outline required documentation for coverage of a nebulizer through the Arkansas Medicaid program. Completed forms and attachments can be submitted by email or fax below, Attention HME.

*** Summary of Documentation Requirements per State Medicaid:**

1) **Copy of script for medication to be used with the nebulizer when that medication is filled at another pharmacy.**
2) **Detailed prescription form for nebulizer (Attached).**
3) **AFMC Prior Authorization Form (Attached). Complete Section B.**
4) **Medication History Report (Attached) as an indication of other treatment options considered.**

We strive to work with all health care providers and clinicians throughout Northwest Arkansas and beyond toward our shared goal of timely and effective patient outcomes.

Please contact us with any questions about this form or suggestions of how we may improve upon this section of our website including other equipment or service category reference documents for which on-line access would be beneficial.

Medical Arts Pharmacy
2515 E. Huntsville Rd
Fayetteville, AR 72701

Phone (479) 443-2102
Fax (479) 443-3412

nwapharmacy@sbcglobal.net

Medical Necessity Form

Patient Name: _____

Date of Birth: _____

Medicaid ID: _____

Equipment Supplied: Nebulizer with compressor

Diagnosis (ICD9): _____

Narrative Explanation: This level of therapy is made necessary by the diagnosis indicated. The patient requires the use of a nebulizer for the purpose of appropriate medication delivery.

Estimated Length of Need: _____

HCPCS: E0570

Provider's Usual and Customary Price: $189.99 purchase

Physician Signature: _____

Date: _____

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER

☐ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS	START DATE:
PROVIDER NAME:	PROVIDER MAILING ADDRESS:
PROVIDER IDENTIFICATION#/TAXONOMY CODE:	PROVIDER PHONE & CONTACT PERSON:
BENEFICIARY NAME: (LAST, FIRST, MI)	BENEFICIARY MEDICAID ID #:
BENEFICIARY MAILING ADDRESS:	DATE of BIRTH: / SEX: ☐ MALE ☐ FEMALE
PRESCRIBING PHYSICIAN:	PHYSICIAN IDENTIFICATION #/TAXONOMY CODE:

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS REQUESTED	UNITS REQUESTED
E0570	NU			Nebulizer with Compressor	1

I attest that the above information is true to the best of my knowledge.

PROVIDER SIGNATURE _____ DATE _____

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED: _____WKS _____MONTHS _____PERM	EPSDT REFERRAL: ☐ YES ☐ NO ☐ N/A	CURRENT HEIGHT: INCHES	CURRENT WEIGHT: LBS
DIAGNOSIS & ICD-9 CODE:	DIAGNOSIS & ICD-9 CODE:	DIAGNOSIS & ICD-9 CODE:	

IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ YES ☐ NO

MEDICAL NECESSITY FOR REQUESTED SERVICES:

PHYSICIAN SIGNATURE _____ DATE _____

**A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required. Please retain a copy of this form in your files.

Send completed form to:
Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters
PO Box 180001
Fort Smith, AR 72918

AFMC-103(4/07)

Medicaid Prior Authorization Request / History Report – Nebulizer

Patient: _____ Medicaid ID: _____

Any medical records received in the course of this request will be used only for the purpose of fulfilling Arkansas Medicaid coverage criteria and will be kept strictly confidential by the requesting provider.

Previous Respiratory Treatments (check one and explain in each of the following therapy categories):

Metered Dose Inhaler:

□ Considered inappropriate and not prescribed for the following reasons:

_____
_____
_____

□ Previously prescribed with insufficient results – Include a brief explanation and any related supporting documentation:

_____
_____
_____

Spacer (with or without mask):

□ Considered inappropriate and not prescribed for the following reasons:

_____
_____
_____

□ Previously prescribed with insufficient results – Include a brief explanation and any related supporting documentation:

_____
_____
_____

Prescription Oral Medication:

□ Considered inappropriate and not prescribed for the following reasons:

_____
_____
_____

☐ Previously prescribed with insufficient results – Include a brief explanation and any related supporting documentation:

_____
_____
_____

PCP Physician's Signature: _____ Date: _____