Blood Pressure Monitor
Detailed Written Order / Delivery Request

Clinic:

Supplier Address	Supplier Phone	Supplier NPI	Supplier Tax ID
19015 S Jodi Road, Ste A, Mokena, IL 60448	708-633-1560	1053364695	201668371

Rep:

Date:

Patient information

First name: _____ MI: _____ Last name: _____

Address: _____ Unit/Apt: ____ City, state, zip: _____

DOB: _____ /_____ /_____ Gender: M F

*Email Address: _____ *Mobile phone: (_____) _____

All orders will be confirmed with the patient prior to delivery ☐ *Marque aquí si decea una llamada en español*

*By providing your email/mobile number, you agree to receive email/text messages from Neb Medical Services. Neb Medical will text you only if additional information is needed to process your order. Text **STOP** to opt out at any time. You may also text **HELP** for assistance. Message and data rates may apply.

Insurance information (please attach a copy of insurance card) | Commercial HMO's require pre-authorization

Primary: _____ ID: _____ Group: _____ Referral #: _____

HMO's require referral/pre-auth

Secondary: _____ ID: _____ Group: _____

Clinic/hospital information | Please print prescribing provider's name and NPI

Provider first name: _____ **Last:** _____ **NPI:** _____

Clinic name: _____ Phone: _____

Address: _____ Suite: _____

City, state, zip: _____

Certificate of Medical Necessity | All fields to be completed by provider

	Equipment prescribed	QTY	Frequency of use	Length of need
X	Auto Blood Pressure Monitor w/ Universal Cuff, 22-42cm, 8.6-16.5 inch **(A4670)**	(1)	1 unit / 5 years	99 months, unless otherwise specified here: _____ months
☐	X-Large Blood Pressure Cuff, 42-48cm, 16.5-18.9 inch **(A4663)**	(1)	1 unit / year	99 months, purchase

Monitor serial number:

Start date of the order: _____ /_____ /_____

Brand / Model number: Medline BP Monitor, Auto, Arm **(MDS3001U)**
Medline BP Cuff, Size XL, **(MDS9973)**

DX: (circle) Essential (primary) hypertension **I10** ***Other:**_____

Brief narrative of medical necessity / directions for use: **(this is a CMS requirement)**

Provider signature: stamped signatures not acceptable **Provider credentials:** **Signature date:**

Fax to Neb Medical Services with a copy of insurance card and HMO pre-authorization – main fax (708) 633 – 1574, alternative fax (708) 995 – 5084