Respiratory Medications and Supplies

Instructions: Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date.

Order Form			
	Referral source (i.e. physician, website)	Follow-up on order status with	Order Date
	Referral source name	Best day to follow-up	Phone
	Referral relation to patient	Best time to follow-up	Email

Patient			Physician	
Name BLN account-seq #	Marital status DOB	Sex Age	Physician name Phone / Email	Company Fax
Bill to address City	Phone / E-mail State Zip County		Physician address City	State Zip
Emergency contact Relationship to patient	Emergency phone Emergency email		DEA # NPI #	State license #

For Physician Use Only: Physician Stamp

Physician Stamp:

For Physician Use Only: Prescription

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX

Dispense As Written

Dispense
☐ 1 Month Supply ☐ 3 Month Supply

Products

Quantity	NDC #, catalog # or product description	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
Quantity	NDC #, catalog # or product description	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code
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Quantity	NDC #, catalog # or product description	Rx - refill # Pay Now Need Rx Auth Req. DME Rider	HCPCS Code

Diagnosis

☐ O92.29 Other disorders of breast associated with pregnancy and the puerperium
☐ O92.011 Retracted nipple associated with pregnancy, first trimester
☐ O92.012 Retracted nipple associated with pregnancy, second trimester
☐ O92.013 Retracted nipple associated with pregnancy, third trimester
☐ O92.5 Suppressed lactation
☐ O92.79 Other disorders of lactation

☐ Other:

Questions

When is your due date?

Primary Medical Insurance		Secondary Medical Insurance	
Plan Name ID #	Group Name Effective Date	Plan Name ID #	Group Name Effective Date
Relationship to member ☐ Self (check and skip section) ☐ Spouse ☐ Child	Member name DOB Member ID #	Relationship to member ☐ Self (check and skip section) ☐ Spouse ☐ Child	Member name DOB Member ID #

Primary Pharmacy Insurance		Secondary Pharmacy Insurance	
Plan Name ID #	Group # BIN # PCN #	Plan Name ID #	Group # BIN # PCN #
Relationship to insured ☐ Member ☐ Spouse ☐ Child	Person Code	Relationship to insured ☐ Member ☐ Spouse ☐ Child	Person Code

Additional Comments

Shipping / Delivery ☐ Expedite

☐ BLN Best Method
☐ UPS ☐ Ground
☐ USPS ☐ Next Day ☐ Second Day
☐ Other ________________

Ship to address ☐ Same as bill to address

Payment

☐ Check
☐ Mastercard ☐ Visa
☐ American Express ☐ Discover

Name on Credit Card

Credit Card Number

Credt Card Expiration Date

For Office Use Only: Routing

Initial	Routed to	Initial	Requested to
	Order Processing ☐ Pharmacy Date mm / dd / yy		Database Management Date mm / dd / yy
	Documentation Date mm / dd / yy		Management Date mm / dd / yy
	Insurance Verification Date mm / dd / yy		New Client / Group Entry Date mm / dd / yy
	Shipping Date mm / dd / yy		Other Date mm / dd / yy

For Office Use Only: Notes

Better Living Now, Inc.
185 Oser Ave.
Hauppauge, NY 11788

Instructions - Please fill in ALL sections and mail or fax along with a copy of the patient's health benefit card to BLN.
If you have any changes, please cross out; write in correction, sign, and date.

1) Patient

a) Please complete the Member section of the order form on the reverse side indicating the insurance you have that provides coverage for your Breast Pumps and Supplies.

2) Doctor

a) Please complete the patient information and doctor information sections.
b) Please indicate the products you want supplied to the patient, with directions for use and quantity required;
c) Please sign and date on the spaces provided.

3) Some Medicare Coverage Rules that should be noted:

a) If treatment regimen exceeds 4 times per day, Medicare requires a detailed explanation of the reason/s: (check all that apply)
  i) o Obstructed Airway (progressive inelasticity of the lungs) o Emphysema o COPD
  ii) o Crackling & Congestion in the lungs o Pneumonia o Wheezing
  iii) o Obstructed Breathing (inflammation of bronchial tubes) o Bronchial Spasms o Asthma
  iv) o Increased Asthmatic Breathing Difficulty o Shortness of breath
b) If treatment regimen exceeds 6 times per day, this completed form must be accompanied by a Letter of Medical Necessity signed by the physician on his or her letterhead.
c) If you fax this document, Medicare/insurance requirements are that you maintain the signed original in the patient's medical record for post-payment review audit purposes.