

# *New Mexico Medicaid Utilization Review*

*P.O. Box 27950 Albuquerque, NM 87125-7950*

## Medical Justification for Nebulizer Compressor (Rental does not require prior approval)

Date: \_\_\_\_\_

Recipient: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

*Circle One*

- |   |   |   |
|---|---|---|
| 1. Does the patient have a respiratory illness that consistently requires the delivery of aerosolized medication? If yes, please provide the medical diagnosis.<br>_____                                    | Y | N |
| 2. Does the patient have a medical condition that results in a chronic production of thick, tenacious secretions which are difficult to expectorate? If yes, please provide the medical diagnosis.<br>_____ | Y | N |
| 3. Is the recipient's condition unresponsive to metered dose inhalers (MDI)?  | Y | N |

M.D. Signature: \_\_\_\_\_