REFERRAL FOR OUT-PATIENT PULMONARY REHABILITION

Patient's Information

Patient's name: _____ DOB: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work/other phone: _____

Email address: _____ Marital status □ M □ S Sex □ M □ F

Referring provider's information

Person completing form: _____

Email address: _____

Referring physician's name: _____ NPI number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Insurance information

Please fax enlarged copy of front and back of Insurance card

Insurance company name: _____ Policy/ID: _____ Group: _____

Customer service/benefits phone: _____ Policy holder: _____ DOB: _____

Authorization: _____

Indications

Duration based on patient progress/risk stratification 3 times/week for 18-36 sessions

□ Chronic Obstructive Pulm Disease	ICD-10 (J44.9)	Date: _____
□ Chronic Bronchitis	ICD-10 (J41-J42)	Date: _____
□ Emphysema	ICD-10 (J43)	Date: _____
□ Lung replacement by transplant	ICD-10 (Z94.2)	Date: _____
□ Asthma	ICD-10 (J45)	Date: _____
□ Bronchiectasis	ICD-10 (J47.1)	Date: _____
□ Pulmonary Fibrosis Unspecified	ICD-10 (J84.10)	Date: _____
□ Pulmonary Fibrosis Interstitial	ICD-10 (J4.89)	Date: _____

Referring provider's orders

The following selected procedure is ordered:

□ **G0424 Out-patient Pulmonary Rehab with exercise & education**
□ **Other** _____

Please fax: (1) recent office notes with clinical indication; and (2) copy of insurance card(s)

Ordering physician's signature: _____ **Date:** _____

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