Telehealth Pulmonary Rehabilitation Patient Referral

Fax to: (818)450-0350

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ Phone: _____

Required: *Attach a demographic sheet that includes current insurance information, most recent office note and PFT (if applicable).*

MEDICAL INFORMATION

- ☐ COPD*+
  - chronic obstructive asthma
  - chronic bronchitis
- ☐ COVID-19 *+
  resulting in at least 4 weeks of respiratory dysfunction
- ☐ Lung Transplant prehab/rehab*+
- ☐ Endobronchial Valves prehab/rehab*+
- ☐ Pulmonary Hypertension**+
- ☐ Interstitial Lung Disease**+
- ☐ Pulmonary Fibrosis**+
- ☐ Bronchiectasis**+
- ☐ Other _____

_____

Diagnosis Coverage Key:
**Medicare Part B (singular diagnosis) **Medicare Part B (combined diagnosis with COPD or Post COVID-19)*
+Medicare Advantage Plans & Commercial Insurances (all diagnoses, singular or in combination)

PROVIDER INFORMATION

Provider Phone: _____ Provider Fax: _____

Practice Contact Name: _____

Practice Contact Email: _____

Provider Print Name: _____

Provider Signature: _____ Date: _____

☐ APP notes include electronic co-sign OR Co-sign Signature: _____

QUESTIONS?

Call: (888)450-0377 Email: team@breathebetter.rehab
www.breathebetter.rehab

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AMERICAN TELEMEDICINE ASSOCIATION Member