Detailed Written Order

Patient's Name: ____Date of Birth: _____________

Address: _________________________________City: ____________________ Zip:___________

Patient's Phone: (Home) ___________________ (Cell) _______________ (Work) _______________

Please Send a Copy of All Insurance Information With This Form

Oxygen

Home Oxygen LPM____________ via NC

❒ Continuous ❒Nocturnal ❒ w/ portable and contents

Test Results: Pulse Oximetry/SaO2__________________

Date Tested: _________ Where tested___________________

❒ Inpatient facility ❒Out Patient

Test Condition:

❒ Nocturnal ❒ Rest ❒ Exertion ❒ Exertion OnO2

PHYSICIAN'S ADDRESS STAMP AND PHONE NUMBER

Diagnosis:

❒COPD (J44.9)
❒ Emphysema (J43.9)
❒ Chronic Bronchitis (J44.9)
❒ Chronic Asthma _______
❒ CHF (I50.9)
❒ OSA (G47.33)
❒ Complex Sleep Apnea (G47.31)
❒ Hypoxia (R09.02)
❒ Central (G47.37)
❒ Other: _______________

Length of Need: X Lifetime ❒ Other:_______________

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: ____ DATE: ____/_____/_____

Print Physician's Name ____ NPI ______________________________