PROGRESSIVE HOME MEDICAL Setting the Standard

Fax 480.895.2949

Referred by_____

Phone 480.802 0202

******Valley Wide Service******

Patient's Name: _____Date of Birth: _____

Address: _____City: _____ Zip:_____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

******Please Send a Copy of All Insurance Cards With This Form******

❒ **Home Oxygen** **at** ___**LPM** via cannula ❒ **Nocturnal** (conc) O2 saturation at night____ Test Date____/_____/_____

❒ **Continuous** concentrator & portable O2 Sats @ rest ____% RA **OR**

_____ Test Date____/_____/_____

❒ Pulse Overnight Oximetry

O2 Sats on exercise on RA_____ O2 Sats. @ rest on RA_____

O2 sats on exercise with O2 _____ Test Date____/_____/_____

Testing on exercise require the 3 saturations above

❒ **C-PAP** _____ **cm H_2O** ❒ **Bi-Level** **IPAP** _____ **EPAP** _____ ❒ **Oral Device**

❒ Heated Humidifier ❒ Chamber ❒ Chin Strap ❒ Disp. & Non Disp. Filters ❒ Tubing ❒ Heated Tubing

❒ Mask (Full or Nasal) ❒ Headgear ❒ Cushions/Pillows **Please Fax Complete Sleep Study & Chart Notes**

Diagnostic Sleep Testing

Type of Testing Requested

❒ **Split PSG** 95811 (Initiate PAP if Medicare/AASM AHI>15hr)

❒ PAP Titration (Previous Diagnostic Study Required)

❒ Consultation by a sleep certified physician

❒ Home Sleep Study (HST)

Indications For Sleep Testing

❒ Observed Apneas/Witnessed ❒ Snoring

❒ Cardiovascular Disease ❒ Obesity

❒ Excessive Daytime Sleepiness ❒Other_____

******Please fax patient's History & Physical & Ins. Card ******

Durable Medical Equipment

❒ **Powerchair** **Other** _____

❒ Manual Standard Wheelchair ❒ Front Wheel Walker ❒ Nebulizer Compressor ❒ Hospital Bed

❒Seat Cushion ❒ Back Cushion ❒Anti Tippers(2)
❒Seat Belts ❒Wheel lock extension extensions(2)

Height: _____ Weight: _____

PHYSICIAN'S ADDRESS STAMP AND PHONE NUMBER

Diagnosis:

❒COPD _____ ❒ Emphysema (J43.9)
❒ Chronic Bronchitis _____ ❒ Chronic Asthma _____
❒ CHF _____ ❒ OSA (G47.33)
❒ Complex Sleep Apnea (G47.31) ❒ Other: _____
❒ 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 _____