GoodCare by CPCI

Home Medical Equipment and Oxygen
450 State Route 664 North● P.O. Box 997 ● Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 ●FAX: (740) 385-0474
242 W. 6th Ave.● Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 ●FAX: (740) 652-9253

Dear Doctor, **Date**_____ **Fax:**_____

Total Pages:_____

Below is the information provided to us confirming your order for home oxygen for:

Patient Name:_____HIC#:_____

Address:_____City:_____State:_____Zip:____

The clinical information provided to us by ◯you; ◉your staff; ◯hospital;_____

included the following:

1. Diagnosis (including ICD-9 code):_____

2. Type of Equipment Ordered (check all that apply):

☐E0424 Stationary Compressed System ☐E1390 Concentrator

☐E0431 Portable Gaseous Oxygen System ☐E0439 Stationary Liquid Oxygen System

☐E0434 Portable Liquid Oxygen System ☐ Oxygen Conserving Device

3 .Date patient last seen:_____

4. **Testing Information**: ☑ABG ☐Pulse Oximetry ☐Test Date:_____Results (please attach copy): P02_☐_ 02 Sat_☐_

Testing Laboratory:_____Conditions (please check one): ◯ At Rest ◯ Exercising ◯ Sleeping: Patient breathing ◯ Room Air ◉ Oxygen during test? If patient was on oxygen, what was the amount?_____

Was patient in a stable state at time of the test? ◯ Yes ◉ No

Was this testing done in the ER, or was the patient in the ER today? ◯Yes ◉No

Was he/she admitted to the hospital today? ◯Yes ◉No

5. Does patient suffer from severe lung disease or hypoxia related symptoms? ◯ Yes ◯ No

If yes, do you believe oxygen will improve the symptoms? ◯ Yes ◯ No

6. Do the patient's lab test results indicate a P02 level or 56-59mm Hg or an arterial 02 saturation of 89%? ◯ Yes ◯ No

If yes, does patient have any of the following?

1. Dependent edema suggestive of congestive heart failure ◯ Yes ◯ No ◯ Does Not Apply
2. Pulmonary hypertension or cor pulmonale ◯ Yes ◯ No ◯ Does Not Apply
3. Erythrocythemia with a hematocrit of greater than 56% ◯ Yes ◯ No ◯ Does Not Apply

7. If portable oxygen is prescribed, what is the reason? _____

8. Estimated length of Need: ◯ Lifetime ◯ 3 months ◯ 6 months ◯ Other _____

9. Oxygen has been prescribed at _____L/Min; for (check one) ◯24 hours a day ◯ during sleep ◯during exertion ◯during sleep and as needed during day ◯ and with exertion

Physician Name _____NPI _____

Attached is the usual Certificate of Medical Necessity which we would ask you to complete, sign, and return by fax to:____(740) 385-0474; _____(740) 652-9253

Thank you very much for your referral.

Sincerely,

02mjf **GOODCARE by CPCI**

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