Oxygen

Physician Order/Prescription

Referred by: Name____________________

Office____________________

Phone #____________________

DATE____/____/________

800-540-7252

Fax completed form with Physician's Signature to 888-651-6709

Patient Information

Patient Name: ____________________ Date of Birth: ____________ Gender M / F

Patient Phone #: ____________ Alternate Contact: ____________ Alternate Phone #: ____________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Insurance & ID# ____________ Group # ____________ Social Security #: ____________

Medicaid #: ____________ Secondary Insurance: ____________

DISCHARGE DATE____/____/________ **DELIVERY DATE____/____/________** **DELIVER TO:** (CIRCLE ONE) **HOME OR REFERRAL**

Products Dispensed

___O2 Concentrator E1390 ___Porto ConcentratorE1392 ___Portable O2 E0431 ___Homefill K0738

Other:________________________________ ___Mask A4620 ___Cannula A4615 Size: ___Adult ___Infant ___Pediatric

Diagnosis Information

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME)

DIAGNOSIS CODE/DESC (ICD): ____________________ DIAGNOSIS CODE/DESC (ICD): ____________________

DIAGNOSIS CODE/DESC (ICD): ____________________ DIAGNOSIS CODE/DESC (ICD): ____________________

LPM_________ Saturation Level__________% Frequency_________ Conserving Lpm_____________

Test was taken (Circle One) (1) At Rest; (2) During Exercise; (3) During Sleep

Prognosis________________________________ Date last seen ____/____/________

Medical Justification ____

PLEASE SEND CLINICAL NOTES

Physician Information

Physician's Name: ____________ Phone #: ____________ Fax #: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

UPIN #: ____________ NPI #: ____________ License #: ____________ Exp Date: ____ / ____ / ____ (MM / DD / YY)

Physician's Signature ________________________________ **Date** ____ / ____ / ____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Approved By