℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
HOME OXYGEN

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

HOME OXYGEN:

Date of Service: _____

Diagnosis and Code:

- ☐ COPD (J44.9)
- ☐ Emphysema (J43.9)
- ☐ Chronic Obstructive Bronchitis (J44.9)
- ☐ Chronic Obstructive Asthma (J44.9)
- ☐ Congestive Heart Failure (I50.9)
- ☐ Cor Pulmonale (I27.81)
- ☐ Interstitial Disease (J84.89)
- ☐ Lung Cancer (C34.90)
- ☐ Hypoxemia (R09.02)
- ☐ Pneumonia, Organism unspecified (J18.9)
- ☐ Other _____

Length of Need (# of months): _____1-99 (99=life)

Patient Height: _____ ft. in. Weight: _____ lbs.

Home System

☐ Concentrator-Stationary Oxygen System (E1390)

Liter Flow: _____ Liters Per Minute (LPM)

Frequency:

- ☐ Continuous, or
- ☐ With Exertion / Activity, or
- ☐ At Rest, or
- ☐ _____ hours per day
- ☐ Range of liter flow and use (i.e. "as needed up to 4 LPM." or "when short of breath,")

_____

Route:

- ☐ Nasal Cannula ☐ Trans Tracheal ☐ O2 Mask
- ☐ Nasal application device for CPAP / BiPAP
- ☐ Other_____

Portable System

☐ Portable compressed gas oxygen system (E0431)

1. Does the patient require the use of portable oxygen to be mobile in their home?
   ☐ Y ☐ N

Optional Equipment

☐ Portable Oxygen Concentrator* (POC) (E1390/E1392)

☐ Home Trans-fill System* (K0738)

☐ Conserving Devise*

Oximetry Testing (* Required):

☐ Titrate oxygen with conserver devise to maintain a saturation of _____% or greater.

LABORATORY RESULTS:

O_2 Saturation: _____ or PO2 _____ on **Room Air** in a state of RESTFUL AWAKENESS

O_2 Saturation on **Room Air** during **Exercise** _____

O_2 Saturation on **Oxygen** during **Exercise** _____

O_2 provided during exercise improved Hypoxemia ☐ Y ☐ N

Date of Test: _____

Note: Test must be completed within 48 hours of Discharge or within 30 days if outpatient and match provider chart notes.

Place Tested: _____

If hospitalized, date discharged: _____

Was test taken within two (2) days prior to discharge from an inpatient facility to home, OR with the patient in a chronic stable state as an outpatient? ☐ Y ☐ N

If O_2 Saturation is >89% or PO2 > 56-59, please check below if applicable:

- ☐ Patient has dependent edema due to congestive heart failure.
- ☐ Patient has cor pulmonale or pulmonary hypertension documented by Pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement.
- ☐ Hematocrit greater than 56%.

If greater than 4 LPM is prescribed: What are test results when taken on 4 LPM?

O_2 Saturation: _____ or PO2:_____

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

_____

Provider's Signature Date

_____

Provider's Name

NPI: _____ Telephone: _____