


**℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
HOME OXYGEN**

Date of Last Provider Visit _____

<p>Supplier Name, Address, Telephone & NSC#:</p> <div style="text-align: center;"> PROCARE HOME MEDICAL</div> <p>4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001</p>	<p>Patient Name, Address, Telephone & HIC#:</p> <p>() - HIC#: .</p> <p>Patient DOB: / / Sex: (M/F)</p>
--	--

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 Device*

Oximetry Testing (* Required):

Titrate oxygen with conserving device to maintain a saturation of _____ % or greater.

LABORATORY RESULTS:

O₂ Saturation: _____ or PO₂ _____ on **Room Air** in a state of RESTFUL AWAKENESS

O₂ Saturation on **Room Air** during Exercise _____

O₂ Saturation on **Oxygen** during Exercise _____

O₂ 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 O₂ 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?

O₂ 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: _____