℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
OVERNIGHT OXIMETRY

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
Procare Home Medical **Phone: (907)-274-0770 Fax: (907) 274-0773** **C/O VirtuOx** **5850 Coral Ridge Drive** **Suite 304** **Coral Springs, Florida 33076** **Phone: (877) 337-1111 Fax: (800) 566-1959**	**(_____) _____ - _____ HIC#:_____.** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

Procare Home Medical has been asked to facilitate this written order request for overnight oximetry with VirtuOx. Please note that VirtuOx is an Independent Diagnostic Testing Facility (IDTF). Procare Home Medical only serves as the courier of the oximeter to and from the patient's home. Courier services by Procare Home Medical are provided at no charge to the patient. All charges for equipment and/or testing are processed by VirtuOx. Testing results are submitted directly to the ordering provider by VirtuOx. We suggest you keep a copy of this for your records.

OXIMETER:

Diagnosis and Code: _____

Length of Need (# of days)_____

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

☐ Overnight Oximetry Test on:
- ☐ Room Air (RA)
- ☐ CPAP/BiPAP
- ☐ Oxygen @ _____ LPM

Special Instruction:

_____

_____

_____

_____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

Does the patient have a condition that requires monitoring of the oxygen saturation level?

☐ Y ☐ N

FAX INFORMATION FOR OXIMETRY REPORTS:

Provider Fax# _____

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: _____