℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION

OXIMETRY & CONSERVING DEVICES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **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.

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.

Equipment:

☐ Portable Oxygen Concentrator (POC) (E1390/E1392)
☐ Home Trans-fill System (K0738)
☐ Conserving Device

Oximetry Testing:

☐ Titrate oxygen with conserver device to maintain a saturation of_____% or greater.

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: _____