

**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
OVERNIGHT OXIMETRY**

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b> <b>Procare Home Medical</b> <b>Phone: (907) 458-8912      Fax: (907) 458-8914</b>  <b>C/O VirtuOx</b> <b>5850 Coral Ridge Drive</b> <b>Suite 304</b> <b>Coral Springs, Florida 33076</b> <b>Phone: (877) 337-1111      Fax: (800) 566-1959</b>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>   <b>(____) _____ - _____ HIC#: _____.</b> <b>Patient DOB: _____ / _____ / _____      Sex: _____ (M/F)</b>
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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:**

Date of Service: \_\_\_\_\_

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: \_\_\_\_\_