

R WRITTEN ORDER AND MEDICAL JUSTIFICATION
OXIMETRY & CONSERVING DEVICES

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:

Patient Name, Address, Telephone & HIC#:



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.

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: _____