

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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#: 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	Patient Name, Address, Telephone & Insurance ID#: () - Ins ID#: _____ Patient DOB: / / Sex: (M/F)
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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). Procure Home Medical only serves as the courier of the oximeter to and from the patient's home. Courier services by Procure Home Medical are provided at no charge to the patient. All charges for equipment and/or testing are processed by VirtuOx. Test results are submitted directly to the ordering provider by VirtuOx. We suggest you keep a copy of this for your records.

OXIMETER:

Overnight Oximetry Test on:
Room Air (RA)
CPAP/BiPAP
Oxygen @ _____ LPM
Length of Need (# of nights): _____
Special Instructions:

DIAGNOSIS AND CODE:

- C34.90 Malignant Neoplasm of unsp. part of Bronchus or Lung
- I27.0 Pulmonary Hypertension
- I50.9 Heart Failure, unspecified
- J42 Chronic Bronchitis
- J43.9 Emphysema
- J44.9 COPD
- J47.9 Bronchiectasis, uncomplicated
- J84.10 Pulmonary Fibrosis
- R06.02 Shortness of Breath
- R09.02 Hypoxemia
- _____ Other: _____

MEDICAL NECESSITY INFORMATION:

Does the patient have a condition that requires monitoring of their oxygen saturation level?
Yes
No

FAX INFORMATION FOR OXIMETRY REPORTS:

Test results are sent directly to your office by VirtuOx.

Provider Fax # for Results: _____

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: _____