HOME OXYGEN STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to :
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

( ) - Ins ID #:

Patient DOB: / / Sex: (M/F)

HOME OXYGEN:

Diagnosis and Code:

☐ Emphysema (J43.9) ☐ Chronic Obstructive Bronchitis (J44.9) ☐ Cor Pulmonale (I27.81) ☐ Congestive Heart Failure (I50.9)
☐ Hypoxemia (R09.02) ☐ Chronic Obstructive Asthma (J44.9) ☐ Lung Cancer (C34.90) ☐ Interstitial Disease (J84.89)
☐ Pneumonia,Organism unspecified(J18.9) ☐ COPD (J44.9) ☐ Other _____

Date of Last Provider Visit: _____ Length of Need (# of months): _____ 1-99 (99=life)

Liters Per Minute: _____ (LPM) _____ hrs/day via ☐ Nasal Cannula ☐ 02 Mask ☐ Trans Tracheal
☐ Bleed into CPAP/BiPAP (to be used during sleep) ☐ Other: _____

Frequency: ☐ Continuous ☐ With Activity/Exertion ☐ At Rest

Stationary Equipment (Please choose only ONE OF THE FOLLOWING) * Depends on stock/availability.

☐ Concentrator-Stationary Oxygen System Only (E1390), up to 10 LPM

☐ Concentrator-Stationary Oxygen System (E1390) AND Portable Oxygen Concentrator (POC) (E1392), up to 3 LPM*

☐ Concentrator-Stationary Oxygen System (E1390) AND Home Trans-fill System (K0738), up to 7 LPM

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: _____ NPI: _____

Provider Name: _____ Telephone: _____