

HOME OXYGEN STANDARD WRITTEN ORDER



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 O2 Mask Trans Tracheal
Bleed into CPAP/BiPAP (to be used during sleep) Other:

Frequency: Continuous With Activity/Exertion At Rest

Oxygen 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: