PULSE OXIMETER 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 #:** **Phone:**_____ **Ins ID#:** _____ **Patient DOB:**_____ **Sex:** _____**(M/F)**

Please fax orders along with required documentation to **(907) 274-0773** or email to **dme@procarehm.com**
Refer to coverage criteria sheet for all required documentation.

PULSE OXIMETER:

Date of Last Visit: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=lifetime)

☐ Continuous (E0445)

_____ # hr/day

Alarm Settings:

Saturation (PO2): High_____ Low_____

Pulse: High_____ Low_____

☐ Probes, Disposable (A4606) - 1/month

☐ Non-Continuous / Spot Checking (E0445)

_____ # times/day

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's Name: _____ Telephone: _____