

**PULSE OXIMETER 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 #:

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: \_\_\_\_\_