℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
OVERNIGHT OXIMETRY

Date of Last Provider Visit_____

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 **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)**

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). Procare Home Medical only serves as the courier of the oximeter to and from the patient's home. Courier services by Procare 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:

_____

_____

_____

_____

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: _____

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:_____

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: _____