TODAYS DME INC

1312 Redwood Ave
Grants Pass OR 97527

Ph 541-249-9860
Fx 541-249-9859
melody.hannah@todaydme.com

Oxygen Detailed Written Order Prior to Delivery

Patient Name: _____ Patient DOB: _____

Order Date: _____ ☐ **Chart notes Attached** (chart notes must include the need for equipment being ordered)

I, the undersigned, certify that the below prescribed equipment/supplies is medically necessary as part of my treatment plan for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment". I have documented the following information and the need for this equipment in the patient's most recent chart notes.

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: ☐ 12 months ☐ 99 months

ICD-10 Diagnosis Code(s): _____

Oxygen Products & accessories are medically necessary (Check equipment/supplies ordered)

QTY	HCPC Code	Description of specific services to be provided
	E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, rental
	E1392	Portable oxygen concentrator, rental
	A4615	Cannula, nasal
	A4616	Tubing (oxygen), per foot
	A9900	Miscellaneous oxygen supply & accessory

Additional Information:

1) The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and	☐ YES	☐ NO
2) Was a qualifying blood gas study provided Date:	☐ YES	☐ NO
3) Alternative treatment measures tried or considered & deemed clinically ineffective	☐ YES	☐ NO
4) Was an oximetry test performed Date:	☐ YES	☐ NO
5) SPO2 testing at rest without oxygen		
6) SPO2 testing at rest with oxygen	SPO2	LPM
7) SPO2 testing during exercise without oxygen		
8) SPO2 testing during exercise with oxygen	SPO2	LPM
9) Was a CMN provided and attached	☐ YES	☐ NO
10) Was the above test performed with the patient in a chronic stable state as an outpatient?	☐ YES	☐ NO
11) If ordering Portable oxygen, is the patient mobile within the home?	☐ YES	☐ NO

Night Time Oxygen LPM _____ Daytime Oxygen LPM _____

Prescribing Physician's Information

Name & Credentials _____ NPI# _____

Telephone _____ Fax _____

Address _____

Signature _____ Signature Date _____