MEDI-RENTS & SALES INC.

800-540-7252

Referred by: Name_____

Office_____

Phone #_____

Oxygen

Physician Order/Prescription

START DATE____/____/_____

Fax completed form with Physician's Signature and Clinical Notes to 844-825-3613

Patient Information

Patient Name: Date of Birth: Gender M / F

Patient Phone #: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance & ID# Group # Social Security #:

Medicaid #: Secondary Insurance:

ORDER DELIVERY DATE____/____/_____ **Deliver to Facility or Home address? circle one**

FUNCTIONAL LIMITATIONS_____FAMILY AND SUPPORT SYSTEM ☐ YES ☐ NO

ABILITY TO USE AND CARE FOR EQUIPMENT ☐ GOOD ☐ NEEDS HELP SUITABLE ENVIRONMENT ☐ YES ☐ NO

Products to Dispense

___O2 Concentrator (E1390) ___Portable O2 (E0431) ___Homefill (K0738) Delivery Method: ___Mask ___Cannula

LPM_____ Frequency of use _____ Maintain Sats @ _____% LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

Diagnosis Information

☐ **J44.9 COPD** ☐ **I50.9 Congestive Heart Failure** ☐ **R09.02 Hypoxemia** ☐ **G12.21 ALS**

☐ **J40 Bronchitis** ☐ **J98.4 Chronic Lung Disease** ☐ **I27.0 Pulmonary Hypertension** ☐ **Other:_____**

Test: Room Air Saturation Level_____% Test was taken (Circle One) (1) At Rest; (2) During Exercise; (3) During Sleep

Saturation Level while ON oxygen _____%

If you are ordering portable oxygen, is the patient mobile within the home? (Circle One) YES NO

Prognosis_____(good, fair, poor, guarded etc.)

Face to Face Encounter Certification: I certify that this patient is under my care and that I, a nurse practitioner or physician's assistant working with me had a face to face encounter related to the medical equipment and /or supplies being ordered that meets CMS requirements on the following date: ____/____/_____

Additional Medical Justification _____

Physician's Name: Phone #: Fax #:

Address: City: State: Zip:

NPI#: License #: Exp Date: ____/____/____ (MM / DD / YY)

Physician's Signature _____ **Date** ____/____/____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Approved By ACHC