We need the information highlighted in YELLOW for the order to be a confirm only for Oxygen.

MEDI-RENTS & SALES INC.

For internal use only!

800-540-7252

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)

Saturation levels need to be 88% or below on room air to qualify for oxygen for most insurances.
Maryland Medicaid saturation 92% or below if the patient is 20 y/o or less.
BCBS saturation 91% or below if the patient is 20 y/o or less.

Get an estimated discharge date and time.

If the patient needs 3 or more LPM they will need a 10 liter concentrator if they are getting a HomeFill, a home fill is used to fill portables in the Home.