Oxygen Order Form

3740 N. Sillect Ave., Ste. 1B
Bakersfield, CA 93308
661.327.5500/661.327.5503fx

Patient Information (attach *patient demographics*)

Name:_____ DOB:_____

Respiratory Diagnoses: _____

Documentation Checklist

In order for us to process Medicare oxygen orders, the following is required:

- ☐ **Patient Demographics** (including copies of insurance cards)
- ☐ **Chart Notes** qualifying patient for oxygen therapy and addressing the following:
  - Severe Underlying Lung Disease Diagnosis
  - Rule out nebulizers
  - Rule out inhalers
  - Oxygen saturations OR arterial blood gases qualifying patient for O2 (grp 1 or grp 2)
    - Testing needs to occur when patient is in a **chronic stable state** (cannot be more than 48 hours before hospital discharge)
    - Qualifying tests are only valid for 30 days
  - Signed/dated by physician

As soon patient eligibility is verified, we will send you a **CMN** for final completion. Patient will be setup promptly upon receipt of CMN. *Medicare will **not** cover oxygen therapy if your patient does not have a severe underlying lung disease diagnosis, and/or if other therapies have not been ruled out (ie. nebulizers, inhalers).*

Group 1 Oxygen
Oxygen saturation below 88% or ABG below 55 mmHg
-at rest
-for at least 5 minutes during sleep
-after exertion

Group 2 Oxygen
Oxygen saturation at 89% or ABG between 56-59 mmHg
AND presence of the following:
-Dependent edema suggesting CHF
-Pulmonary hypertension/cor pulmonale
-erythrocythemia with hematocrit over 56%

IF O2 sats are 90%+ and/or ABG 60+ mmHg, patient does NOT qualify for coverage of Oxygen.

Equipment Ordered

	Oxygen Concentrator
	Portable Oxygen
	Cannulas
	Tubing
	Humidifiers
	Connectors

Liter Flow _____ HPD _____

Length of Need _____

By signing below, I agree that the above listed equipment is medically necessary for this patient and that I will sign and complete Medicare Certificate of Medical Necessity (DME Form 484.3).

Physician Information

Prescribing Physician:_____ NPI Number:_____

Address:_____ City:_____ State:____ Zip:_____

Fax Number:_____ Phone Number:_____

Physician Signature:_____ Date:_____

Unless otherwise specified, it is assumed that this signature date is the therapy start date