



Oximetry & Conserving Devices

Written Order

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Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

OXYGEN:

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Diagnosis and Code:

- ☐ COPD (J44.9)
- ☐ Emphysema (J43.9)
- ☐ Chronic Obstructive Bronchitis (J44.9)
- ☐ Chronic Obstructive Asthma (J44.9)
- ☐ Congestive Heart Failure (I50.9)
- ☐ Cor Pulmonale (I27.81)
- ☐ Interstitial Disease (J84.89)
- ☐ Lung Cancer (C34.90)
- ☐ Hypoxemia (R09.02)
- ☐ Pneumonia, Organism unspecified (J18.9)
- ☐ Other: _____

Equipment:

- ☐ Portable Oxygen Concentrator (POC) (E1390/E1392)
- ☐ Home Trans-fill System (K0738)
- ☐ Conserving Device

Oximetry Testing:

- ☐ Titrate oxygen with conserver device to maintain a saturation of _____ % or greater.

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: _____ NPI: _____

Providers Name: _____ Telephone: _____