



Pulse Oximeter Standard 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.

PULSE OXIMETER:

Diagnosis and Code: _____

Date of Last Visit: _____ Length of Need (# of Months): _____ 1-99 (99=life)

☐ Continuous (E0445)

_____ # hr/day

Saturation (PO2): High _____ Low _____

Pulse: High _____ Low _____

☐ Probes, Disposable (A4606) – 1/month

☐ Non-Continuous/Spot Checking (E0445)

_____ # times/day

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: _____