Home Oxygen Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

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

Refer to coverage criteria sheet for all required documentation.

HOME OXYGEN:

Diagnosis and Code:

☐ Emphysema (J43.9) ☐ Chronic Obstructive Bronchitis (J44.9) ☐ Cor Pulmonale (I27.81) ☐ Congestive Heart Failure (I50.9)

☐ Hypoxemia (R09.02) ☐ Chronic Obstructive Asthma (J44.9) ☐ Lung Cancer (C34.90) ☐ Interstitial Disease (J84.89)

☐ Pneumonia, Organism unspecified (J18.9) ☐ COPD (J44.9) ☐ Other _____

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

Liters Per Minute: _____ (LPM) _____ hrs/day via ☐ Nasal Cannula ☐ O2 Mask ☐ Trans Tracheal

☐ Bleed into CPAP/BiPAP (to be used during sleep) ☐ Other: _____

Frequency: ☐ Continuous ☐ With Activity/Exertion ☐ At Rest

Oxygen Equipment: (Please choose only ONE OF THE FOLLOWING) *Depends on stock/availability.

☐ Concentrator-Stationary Oxygen System Only (E1390), up to 10LPM

☐ Concentrator-Stationary Oxygen System (E1390) AND Portable Oxygen Concentrator (POC) (E1392), up to 3 LPM*

☐ Concentrator-Stationary Oxygen System (E1390) AND Home Trans-Fill System (K0738), up to 7 LPM

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: _____