Overnight Oximetry Written Order

Fax: 602-428-6841
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Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

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

Date of Last Visit: _____

Refer to coverage criteria sheet for all required documentation.

OXIMETER:	DIAGNOSIS AND CODE:

☐ Overnight Oximetry Test on:
- ☐ Room Air (RA)
- ☐ CPAP/BiPAP
- ☐ Oxygen @ _____ LPM

Length of Need (# of Nights): _____
Special Instructions: _____

_____

_____

_____

MEDICAL NECESSITY INFORMATION:

Does the patient have a condition that requires monitoring of their oxygen saturation level?

☐ Yes
☐ No

☐ C34.90	Malignant Neoplasm of unsp. Part of Bronchus or lung
☐ I27.0	Pulmonary Hypertension
☐ I50.9	Heart Failure, unspecified
☐ J42	Chronic Bronchitis
☐ J43.9	Emphysema
☐ J44.9	COPD
☐ J47.9	Bronchiectasis, uncomplicated
☐ J84.10	Pulmonary Fibrosis
☐ R06.02	Shortness of Breath
☐ R09.02	Hypoxemia
☐ _____	Other: _____

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: _____