Oximetry & Conserving Devices Written Order

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

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: _____