Pulse Oximeter Standard Written Order

Fax: 602-428-6841
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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: _______________________