Diagnostic Medical Testing

Your Home Medical Visits Provider

Patients Are Our First Priority

Overnight Oximetry Request

Prescription Order Form

Fax Form to: 866-573-0311

Patient Information

Patient Name: _____ ○ Male ○ Female DOB: _____

Address: _____ City/State/Zip: _____

Phone: _____ Alt Phone: _____ Email: _____

Primary Ins: ○ Medicare ○ Medicaid ○ Commercial Plan: _____ ID#: _____

Secondary Ins: ○ Medicare ○ Medicaid ○ Commercial Plan: _____ ID#: _____

Please fax insurance cards along with completed paperwork for ALL Non-Medicare Patients.

Local HME Supplier: _____ Contact: _____

Phone: _____ Fax: _____ Email: _____

Ordering Physician: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

Patient Diagnosis – One Must be Checked

○ I27.81 (Cor pulmonale)	○ G47.30 (Unspecified SA)	○ R06.89 (Resp. Abnormality)	○ J45.998 (Asthma – Unspec.)
○ J44.9 (COPD)	○ J45.901 (Asthma – Acute)	○ I27.9 (Pulm. Heart Disease)	○ I50.9 (Heart Failure-Unspec.)
○ R06.02 (SOB)	○ R09.02 (Hypoxemia)	○ G47.10 (Hypersomnia)	○ Other:
○ J84.10 (Pulm. Fibrosis)	○ J43.8 (Emphysema)	○ J43.9 (Emphysema Unspec.)	

Diagnostic Orders & Physician Certification

Overnight Oximetry Test to be performed on:

○ **Room Air** ○ **Oxygen at _____ LPM** ○ **CPAP/BiPAP/APAP** *(Circle One)* ○ **CPAP/BiPAP w/ Oxygen at _____ LPM** *(Circle One)*

By signing below, I certify that I am ordering an overnight pulse oximetry (94762) for this patient listed on this prescription. The DME/HME company shall courier the pulse oximeter and process the data electronically through the IDTF listed above.

Physician Signature: **X** _____ Date: _____

Physician once signed, fax this form to the HME Courier at: _____

HME Courier, please fax this form BEFORE DELIVERING the pulse oximeter to your patient!

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