

Phone: 800-824-1400

Fax: 877-824-1411



RESPIRATORY Fax Order Form

Please provide copy of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____

Address : _____

City/Zip: _____

Home Phone/Cell#: _____

Height: _____ Weight: _____ D.O.B: _____

All services require a method of payment (Credit Card, Bank Information) in addition to Insurance information prior to delivery.

EMPLOYEE USE ONLY CC secured

Date Prescribed: _____/_____/_____

Insurance: _____

Diagnosis: _____

Gender: _____ Length of need: _____ 99

- Asthma (493) Bronchiectasis (494) Hypoxemia (799.02) Chronic Obstructive: Bronchitis (491.2) Asthma (493.2) CHF (428.0) COPD (496) Emphysema (492) OSA (327.23) CSA (327.21) CVA (436) Abnormality of gait (781.2)

OXYGEN (humidifier, tubing and all related supplies)

Oxygen LPM: _____ Via: _____ Rest w/Exertion Sleeping Continuous

Concentrator Portable Oxygen Gas Tank

Evaluate for Conserving Device (provide if appropriate) Maintain O2 Sat: _____ % (during evaluation)

Per MSC protocol: If minimum is not indicated, O2 Saturation will be maintained at a minimum of 90%. In addition, MSC will also conduct comprehensive oximetry prior to d/c of O2

PULSE OXIMETRY SERVICES (where available)

- Comprehensive Oximetry On Room Air On Oxygen LPM Overnight Oximetry On Room Air On Oxygen LPM While on PAP Therapy

- SUCTION Machine oral trach Yankauer Catheter size Canister Tubing 50 psi compressor device supplies

NEBULIZER & RESPIRATORY MEDICATIONS

- Nebulizer, Frequency of Usage Disposable Admin Set Non-Disposable Admin Set Disposable Neb Filter Neb Mask Medication name, dosage & frequency (if prescription info is not present)

CPAP/BI-LEVEL with heated humidity (tubing, filters & all related supplies) PLEASE INCLUDE COPY OF SLEEP STUDY

- CPAP cm H2O APAP to cm H2O Humidifier Heated Humidifier Bi-PAP IPAP = EPAP = BiPAP Auto EPAP min = IPAP max = PS Bleed in O2 @ LPM

- Mask & Supplies Mask of Patient Choice (please indicate) Nasal with Cushions Full Replacement Cushion for Nasal CPAP Replacement Pillows CPAP/BiPAP Headgear used w/CPAP/BiPAP CPAP/BiPAP Tubing CPAP Filter, Disposable (A7038) CPAP Filter, Reusable (A7039) Water Chamber Chin Strap Non-Heated Tubing Heated Tubing Other

Height and Weight required for these items:

Ambulatory _____ Wheelchairs & Accessories _____ Hospital Beds & Accessories _____ Other _____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND 1) Patient Name 2) Date Prescribed 3)Physician Signature 4) NPI

Physician's Signature: _____

Date: _____/_____/_____

Physician's Printed Name: _____

Ph: _____ Fax : _____

Address: _____

NPI: _____